STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

BUSINESS MEETING

TRANSCRIPT OF PROCEEDINGS

August 7, 1997

9:30 A.M.

107 South Broadway
Auditorium
Los Angeles, California

REPORTED BY:
Corinne L. Horne,
CSR 8712
Our File No. 38392

ATTENDANCE:

ALAIN C. ENTHOVEN, CHAIRMAN

Bernard Alpert	Maryann O'Sullivan
Rodney Armstead	John Perez
Rebecca Bowne	John Ramey
Harry Christie	Anthony Rodgers
Barbara Decker	Helen Rodriguez-Trias
Martin Gallegos	Ellen Severoni
Bradley Gilbert	Michael Shapiro
Diane Griffiths	Terry Shaw
Terry Hartshorn	Alice Singh
William Hauck	Hattie Skubik
Mark Hiepler	Bruce Spurlock
Michael Karpf	David Tirapelle
Clark Kerr	Jennifer Tachera
Peter Lee	David Werdegar
Stuart McVernon	Ronald Williams
J. D. Northway	Steven Zatkin

I N D E X

THURSDAY, AUGUST 7, 1997, LOS ANGELES, CALIFORNIA

DR. ENTHOVEN: I'd like to call the meeting to order. The Managed Care Improvement Task Force will now come to order.

We'll begin with Mr. Stuart McVernon. Is Mr. Stuart McVernon here to call the roll?

Please significant "aye" if you're present. Signify "no" if you're not present.

MR. McVERNON: Alpert.

DR. ALPERT: Aye.

MR. McVERNON: Armstead.

MR. ARMSTEAD: Aye.

MR. McVERNON: Bowne. Conom. Decker. Enthoven.

MR. ENTHOVEN: Aye.

MR. McVERNON: Farber. Finberg.

MR. CHRISTIE: Here.

MR. McVERNON: Gallegos. Gilbert.

MR. GILBERT: Here.

MR. McVERNON: Griffiths. Hartshorn.

MR. HARTSHORN: Here.

MR. McVERNON: Hauck.

MR. HAUCK: Here.

MR. McVERNON: Hiepler.

MR. HIEPLER: Here.

MR. McVERNON: Karpf.

DR. KARPF: Here.

MR. McVERNON: Kerr.

MR. KERR: Here.

MR. McVERNON: Lee.

MR. LEE: Here.

MR. McVERNON: Murrell. Northway.

MR. NORTHWAY: Here.

MR. McVERNON: O'Sullivan.

MS. O'SULLIVAN: Here.

MR. McVERNON: Perez. Ramey. Rodgers. Rodriguez-Trias.

MS. RODRIGUEZ-TRIAS: Here.

MR. McVERNON: Severoni.

MS. SEVERONI: Here.

MR. McVERNON: Spurlock. Tirapelle. Williams.

MR. TIRAPELLE: Here.

MR. McVERNON: Zaremberg. Zatkin.

DR. ENTHOVEN: Barbara Decker is here.

MS. DECKER: And Perez is here.

DR. ENTHOVEN: Does that give us a quorum?

MR. McVERNON: Belshe. Berte. Bishop.

MR. BISHOP: Here.

MR. McVERNON: Knowles. Rosenthal. Shapiro.

MR. SHAPIRO: Here.

MR. McVERNON: Werdegar.

MR. WERDEGAR: Here.

DR. ENTHOVEN: A quorum is present.

First I'd like to extend to you Phillip Romero regrets for not being here. He was not able to

come. He's, temporarily -- I hope, temporarily out of commission with a medical problem. He is an HMO, you know. But he says that he's been receiving excellent care.

Thank you very much for coming. I think your presence shows your dedication to this important work. We do face a very important challenge. As well as reporting on the facts relevant to managed care in this state, which we've been charged to do, we've been asked to recommend a regulatory framework for this industry so that it can function effectively to satisfy patients and also control costs.

Every industry has a regulatory framework intended to make the market work well for consumers. You think of transportation, automobiles, securities, agriculture. So it's not an extraordinary thing that this industry also needs a regulatory framework. And its special characteristics make that particularly important.

So we need to make recommendations to the legislature, to the governor, as to what the system and the rules ought to be. We have not been asked, nor do we intend, as a task force to review specific legislation. That's not part of our responsibility. But our responsibility is to develop a coherent overview for the role of government about how and what should be regulated.

The task force is making good progress. As I said at the last meeting, our general plan is to phase down the outside presentations as we build up a backlog of

accumulated information for the members and then to phase in presentations of the work of the task force members and staff.

I've recently sent you -- you'll probably be receiving soon in the mail a very interesting article by Clark "Havenger," who is a very distinguished professor of law at Duke University and one of the pioneers of the whole question of health care, finance, and organization with particular focus on its legal aspects. It's an article entitled something like "Holding Healthplans Accountable for Quality."

I don't believe I come out with exactly the same points that he does. I'm not sure. But I do agree with him that health plans should be legally accountable for damage caused by coverage decisions. And I know that's an issue that's on the minds of a number of members of the task force.

This issue is very complex with some surprising twists. Like when this idea was floated in the Clinton task force that the people who turned out to be for it and against it were different in the end from who they were at the beginning. And it eventually was shot down.

But he argues that it's in the best interests of health plans so -- to accept legal responsibility. So this is not HMO bashing or anti-HMO in any sense. In fact, some people didn't like the idea because they thought it would HMO's too powerful. But Kaiser

Permanente accepted enterprise liability for years presumably because they thought it was the best thing to do.

So please read this article and think about it and let me know what you think about it. Because if there's interest, we would be interested in scheduling some time for the task force to discuss it.

On another item, the governor's veto of the Davis bill -- actually, I think that it was the way and the reasons as much as the veto, not more -- have caused concern among some members who have spoken to me about this and whose remarks I've read in the press.

And so I believe these concerns need to be aired and that it would be appropriate to be sure people, task force members in particular, who feel the concerns, have an opportunity to say something about it.

So what I would like to request of the task force is unanimous consent for a change in the order, that we would deal with the business items first, because it's important we go through those and then we discuss the role of the task force in legislation issue. But I request that we do that fairly crisply and expeditiously so that people can make their points and then move on.

We have a good fortune this morning that we have Assemblywomen Susan Davis and Liz Figueroa, who have introduced legislation, who would like to address the task force. And we will take advantage of their presence at that same time for them to talk to us.

However, out of respect for the excellent work and the excellent presentations that our members have been doing, I request that we get through that fairly quickly so that we can get on with our schedule of work.

With that, I would like to proceed with the consent calendar. The next --

MR. COURT: Excuse me, Mr. Chairman. I had a request in for a public comment on agenda item No. 3. And I believe public comments, according to the notes, will be accepted on agenda items during their discussions. If I could have a minute to make a public comment on that agenda item.

My concern about the governor's veto --

DR. ENTHOVEN: Please identify yourself.

MR. COURT: Jamie Court. I'm the director of Consumers for Quality Care Consumer Advocate, and what I'm asking the committee to consider throughout this whole agenda, given the role you've laid out in your opening remarks, is that this is a private task force that needs to send sometime during this agenda a message to Governor Wilson that it does not legislate, that it is simply an appointed body that make representations and that Governor Wilson should deal with legislation this year.

The 88 reform bills that are waiting in the legislature are bills that patients can't wait another year for. And I truly believe from the consumer advocate community that if this committee can't send that strong message that patients can't wait another year for the

reform, then this committee must make consciousness decisions about whether to continue this process.

I call upon members either to send a strong Shermanesque message statement to the governor about this committee's role and its recommendation that the governor deal with legislation on its merits this year -- that's the public process -- or that you consider resigning from the committee.

And I ask that of the people who have high morality on this committee -- consumer advocates, doctors of the HMO industry. I ask you to consider this: You have the votes on this committee to do what you want with it. My concern is that you recognize that if the public process is stopped, if no bills for HMO reform are done this year in the legislature, then what will happen is we will go to the initiative process with reform that you may really not like and have a say in, reform that deals with consumers' concerns but that isn't as bold as what you may shape in the legislative process.

So I call upon both members who are members of the consumer advocate and medical community and the HMO community to consider sending a letter to the governor.

I see agenda No. 7 that there's not going to be a vote on this today. And I think absent a vote, your path is clear because everyone in Sacramento has their eyes on you, and we hope that you will do the right thing. And we'll be watching. Thank you.

DR. ENTHOVEN: Thank you, Mr. Court.

The next order of business will be to adopt the consent calendar which consists of two documents: the June 20 business meeting minutes, the adoption of amendments to task force standing rule No. 1, the task force meeting hearing schedule.

In the case of the hearing schedule I'd like to announce there was a typographical error, and the printed version says September 26 but actually is meant to be September 23. So I'd appreciated it if you would correct that on your calendar.

With that, I would entertain a motion to adopt the calendar. In your package that's item 4A and 4B.

MR. HAUCK: I move to accept the calendar.

MR. PEREZ: Second.

DR. ENTHOVEN: All in favor?

MEMBERS: Aye.

DR. ENTHOVEN: Opposed?

Thank you very much. So the consent calendar has been adopted and then adoption of the June 20, 1997, business meeting minutes.

Now we go on to new business. Discussion and adoption of the amendment to the task force bylaws regarding the creation of policy options working groups. This is the next item of business. It's tab 5A.

The idea with policy options working groups is now to create more aggregated groups to meet on the broader groupings of these topics that we're studying.

Ms. Singh, do you want to comment on the proposed technical amendments?

MS. SINGH: Mr. Chair, these are just technical amendments basically establishing authority for the chair to appoint the policy options work groups. They're technical in nature. It doesn't mean you have to adopt these particular groups. It gives us the authority to do so.

DR. ENTHOVEN: Is there any discussion?

MR. HAUCK: I move the adoption.

MR. PEREZ: I second.

DR. ENTHOVEN: All in favor?

MEMBERS: Aye.

DR. ENTHOVEN: Oppose?

They are adopted.

We will move on to what was noticed as discussion of the task force's rule regarding ongoing legislation. As I said in my opening remarks, we have not been asked, nor do we intend as a task force to review specific bills because we are not a legislature body. What we have been asked to do is provide a coherent overall recommended framework for how this industry should be regulated, something that we hope would shed light on specific legislative proposals.

Are there members of the task force who would like to comment on this issue -- excuse me. I think I'd like to begin by introducing Assemblywomen Susan Davis and Liz Figueroa.

Would you come up, please. We have a table here with a microphone.

Each will comment briefly on their thoughts on this issue.

ASSEMBLYWOMAN DAVIS: Thank you very much for the opportunity to speak to you today on such short notice. I felt that it was important for us to be here and to sincerely -- we sincerely appreciate having your attention.

As you know, I happen to have the first piece of managed care legislation to reach the governor's desk and to be vetoed. The bill would have allowed women to go directly to their OBGYN without having to ask permission of a gatekeeper.

It will probably relieve you to know that I'm not here to talk about the merits of this bill or any other. I can assure you that my colleagues would all be here if they felt that they would have your ear on their important pieces of legislation.

But I am here to express my concern and that of many of my colleagues for the position that you have been placed in, vis-a-vis, the status of bills currently moving through the legislature.

Governor Wilson says that he vetoed AB 1354 and will veto all other HMO bills with one exception, Ms. Figueroa's bill, because he wants to wait for your report in January. Although he has stated that he doesn't expect the task force to assume responsibility for the

consideration of specific bills -- and I appreciate the comments of your chairman on that regard -- the effect of the governor's action is to set up the expectation that this body rather than the duly constituted legislature will determine whether or not certain laws are needed by the people of California. The task force is being used as the rationale for the veto of legislation.

I suspect that that makes many of you uncomfortable, along with many of us who voted for the task force legislation. As a result, I appear before you today with one simple request, again, not to ask you to review the merits or demerits of one or all pieces of managed care legislation, but to ask you to collectively discuss and develop as soon as possible a clarification of your role in the legislative process.

A statement of your position on how the task force is being used as the rationale for delaying health care policy worn by the people's representatives would be very helpful at this time. And I appreciate the fact it is on your agenda today and that in fact you will have that discussion right away this morning.

I want to say just a few words, on closing, on the legislative process. Believe me, I can assure you that I often feel frustrated that we are not able to deal as comprehensively as possible with all matters that come before us. People actually heard me speak when I moved to the legislature, and particularly as it regards the health committee, that we need to look at some of the issues more

globally.

Legislation, however, is measured, and it is incremental. It takes a process of consensus building and compromise. And ultimately my colleagues and I are responsible for whether or not sound, common sense legislation is enacted. And we have frequent performance reviews. For all its shortcomings, it is in the public realm that pacific policy decisions should be made.

In my opinion, this task force can serve a very useful role in providing important parameters and yardsticks for us to consider in contemplating future changes to our managed care system.

Your charge -- and I think it's been well publicized -- is to study broad health issues that may or may not find their way into future health legislation or policy. It is my understanding that this is consistent with your legislative mandate and will certainly be welcome by me and by my colleagues who would utilize the analyses and the suggestions made by the task force. Clearly, our respective role should be complimentary, not in conflict.

In closing, I just want to thank you very much for your generosity of time this morning and recognize all of you for the important and time-consuming task that you have undertaken. I hope that my request here for a clear statement of your role is understood and taken within the collaborative spirit with which it is given.

Thank you very much, and I welcome any questions.

DR. ENTHOVEN: Thank you very much, Ms. Davis.

Do any of the task force members want to -- okay. Mark Hiepler.

MR. HIEPLER: Ms. Davis, given the circumstances of a lot of pending important legislation that has its own timetables, takes a long process, and has gone through a lot just to get where it is, what would you want the committee to do, given the apparent position that looks like everything is riding on what we say? And I don't think any of us are going to have the specific recommendations that the needs of your constituents are discussed in each of your bills.

What could we do at this point to help clarify that for you?

ASSEMBLYWOMAN DAVIS: I think collectively I would hope you might come to a consensus on the task force of how you would like to communicate to the governor particularly and to the legislature what you believe your position, vis-a-vis that legislation, to should be. That would be very helpful for us. It would provide a clarification. And, again, I think that the governor has to make his decision. You know, that's what we pay him to do and elect him to do.

But we need to hear from you. That would be helpful at this time. Individuals have spoken on their

own, but I think it would be very helpful as a panel to hear that.

MR. HIEPLER: Having seen the legislation, do you believe the committee should take a vote like Mr. Court recommended on whether we recommend to the governor that he should continue the way that he's interpreted this? To put everything on the shelf until we make some broad general recommendations? Or do you think that that's something you want done?

ASSEMBLYWOMAN DAVIS: I would be very happy if you could communicate back in whatever way you feel appropriate. A clear statement would be very helpful.

MR. HIEPLER: And on this specific issue, should we wait -- should he veto all bills, until we get done, and come up with a great scheme, as opposed to letting legislature take its process? I mean that's specifically just to go right to the issue.

ASSEMBLYWOMAN DAVIS: Yes. People have worked hard. We have constituents who have brought tremendous concerns to us as it relates to their health care. They do not want to wait for the task force. It may be that, again, within the legislative process decisions have to be made. We understand that. And not all the bills would be passed under normal circumstances. But this is a rather unusual circumstance that we're facing right now.

MR. HIEPLER: Thanks.

DR. ENTHOVEN: Any other members?

Ms. Figueroa?

ASSEMBLYWOMAN FIGUEROA: Thank you, Mr. Chairman, and members of the task force. My name is Liz Figueroa, assemblywoman from the 20th assembly district, and I'm the chair on the insurance committee for the assembly. It's odd that I'm here because I'm the author of that one exception that the governor has stated that he will entertain in signing.

But I'm here because the issue is a lot more important than one specific bill. The whole issue of HMO reform that's before you and before the legislature is very important to meet the needs of many of my constituents and the constituents of Ms. Davis and many of the legislators.

I have a constituent Nancy "Tushow" that came to me with the issue of a mastectomy. That's where the whole issue of the mastectomy bill, the drive for the mastectomy, came. It didn't come because we wanted front page headlines or because we thought it was a politically astute move. It came because a constituent told me that she had asked to stay overnight, and she couldn't. And she had medication. She had tubes for drainage. And she had to be sent home and had an elderly husband to take care of her. And she didn't know how she was going to manage that, and she was outraged and wanted me as her legislator to do something about it.

We also -- I'm here for another constituent, Peter Berman, who went to testify before the senate

insurance committee. His wife is dying, who is in a coma. He was watching the time very closely because every hour that he was there to testify or to wait for the committee to meet meant precious time that he could have spent with his wife. We're talking about -- and I don't have to tell you this. You already know. We are speaking about life and death situations.

As a member of the legislature, I'm a conduit. I am the voice of the people. And now so many pieces of legislation have gone through the various policy committees. Some have been successful. Some have not.

I don't know what to say to Nancy Tushow now or to Peter Berman. I know they can't be here. I know that they're going through chemotherapy. They're having to work their loved ones through comas and various ailments. I don't know how to respond to them. Do I tell them that now we have to go through another policy committee? Do I tell them that now every piece of legislation is going through this task force?

We need to come through a consensus and provide a clear message to respond to the needs of the constituency. Many of these people could not wait for a year or two. They need answers immediately.

So I thank you for considering the comments of my colleague, Susan Davis, and those that I've made. And I know some of our colleagues have provided letters of our need for some clear message as to what you see your role and how we could work together to respond to the

needs of our constituents throughout the state of California.

DR. ENTHOVEN: Thank you, Ms. Figueroa.

Task force members?

Michael.

MR. SHAPIRO: I believe each of you have received a letter from Senator Rosenthal and Assemblymember Gallegos, who expressed their regret for not being able to attend today -- to take a very hard look at this issue. This is deja vu as far as Senator Rosenthal is concerned. He had a bill vetoed last year. The HMO report card bill, which I provided to you, where the governor asked this task force to review that legislation.

Specifically, we then spent months trying to resolve that issue and thought we had a commitment from the governor's office that the governor would look at bills on the merits. And members do not mind getting a veto on the merits which they can deal with and they can return and respond to.

We cannot deal with a veto that delegates to this body the ability to influence legislation, a body which is conflicted on this issue with many members having taken positions on legislation before the legislature.

Now, our hope in the correspondence that's been sent to you is to urge the governor to reconsider his position and to have this body support that effort to bring together key members of the legislature and possibly

members of the task force to undo what the governor has done, which is to politicize this process. All eyes are now on this body.

I have had numerous calls from members with bills who are confused. What if the report that comes out of this committee doesn't deal with my issue? How will the governor deal with that bill on mastectomy? On prostrates? On second opinions? They're not going to deal with those issues. There's no support for my bill. My bill is not even being considered in the context of this body. I have disclosure bills on specific information. I've got other bills. You know, I know the pejorative "piecemeal" has been used.

We have had oversight hearings on HMO mergers, on HMO privacy issues. We've had national experts come in, who have spent two years on these issues, which are not even being considered by this body. We have compromised. We have taken amendments by the administration provided by Mr. Bishop over here, provided by others. We have take amendments from the HMO industry.

These bills have been negotiated. They have been compromised. It's incremental because the legislature has been told that's all we can accomplish. No member of the legislature, that I'm aware of, would have voted to establish this task force if they had known how it would be used and abused by the governor. And if you want to be party to that, you have to expect what may come next, which is excruciating oversight.

My boss got a call from the "L.A. Times" yesterday wanting to know about conflict of interest from the members of this. We have been asked about your designations. Who are the true consumers? Who are the enrollees? Who are the providers?

The same kind of scrutiny the legislators get, when they are carrying legislation, is now heaped on your shoulders. Because you have been delegated a new function that was unintended. Now we would like to undo that. We thought we had a commitment.

Mr. Bishop's confirmation almost failed on this issue in terms of this body being used to hold up legislation. There's confusion. There's concern. And there's criticism in this body. It's already being damned by consumer groups it's industry dominated. We have not had that criticism from my boss and others.

But you have now become a quasi-legislative body for better, for worse, whether or not you invited it. And I urge you to consider whether this body will have any credibility and any potential to do good work as intended by the original author, who spoke before you on the first day and said "This is not a black hole for legislation."

And if you just dismiss this briefly -- and we never intended to do this, and this is the governor's call -- then, you are abdicating responsibility to do the work you were called on to do when you were appointed, including the appointees of the legislature.

This issue has been around for a long time.

It's only coming to a head now because all members of the legislature, not just Senator Rosenthal, have suddenly been victimized by abuse of this body as a tool to delay legislation.

I want you to know that almost all opposition letters I have from HMO's to our bills say "Hold it off and study that bill in the task force. Study that HMO bill on mergers in the task force." That's what the HMO's have been writing to us and to the governor for six months. And it worked. And it's up to you to decide whether you're going allow that to work.

Thank you.

DR. ENTHOVEN: Thank you, Mr. Shapiro.

Rebecca Bowne.

MS. BOWNE: I recognize and respect with passion with which Mr. Shapiro has spoken. I happen to agree with him. But I would like to bring up an additional point that I think that we as the commission are facing regularly.

There will always be untoward events that happen within the health care system. There will be individuals that have a particular set of circumstances that are most unfortunate. And I would plea with -- is it assemblywoman or senator Figueroa?

ASSEMBLYWOMAN FIGUEROA: Assemblywoman at present.

MS. BOWNE: I think it is unfortunate when either we, as a commission, or the senate of the assembly,

allow individual medical incidents to drive good public policy.

While I would certainly echo Mr. Shapiro in saying that we cannot permit this commission to be another study group that delays and obfuscates action by our elected bodies. We equally cannot be so swayed individual incidents, not collections of incidences, patterns of incidences. Those, we need to take into account so that we can have a viable, strong, in my opinion, private -- I realize that's not 100 percent shared by everyone -- medical care delivery system.

So while I would certainly echo the notion that I think that we need to let the legislature get on with its business. And I'm an appointee by Governor Wilson. I'm a supporter of his. But I think somehow there has been some untoward circumstances that have led to this situation which, allowed to continue, would be most unfortunate.

At the same time, I would like to share with members of the public who come before us. Each incident builds a pattern and a history and a mosaic that creates a situation that we face and we listen to in our research and deliberations to help us build a stronger health care system. But I would also plead that we not let individual untoward incidences have us make bad public policy.

DR. ENTHOVEN: Thank you very much, Ms. Bowne.

Do you want to comment on that?

ASSEMBLYWOMAN DAVIS: If I could respond briefly, I think that to the best of our ability, we try and do that every day. What's difficult, as I'm sure you can relate with me, is that just like beauty, I think micromanaging is probably in the eyes of the beholder, and what might be micromanaging to one person in the system may well not be to another. Because we believe that those are not episodic or an anecdotal stories, but in fact they do represent a pattern of care that we think we need to address.

DR. ENTHOVEN: Thank you.

Other task force members -- may I be sure -- we have called to attention the letters from Martin Gallegos and Herschel Rosenthal. We also received letters from Assemblyman Brett Granlund.

Does everyone have that also?

MR. RANDALL: Professor Enthoven, I'm Jim Randall. We're the sponsors of the bill that Ms. Davis has. I want to speak to the Brett Granlund letter and make the point that he's a republican. You have here two democrats before you. The governor is a republican. But there are many republicans that have this legislation. And as you can tell by Mr. Granlund's letter that the republicans share his concerns as well.

DR. ENTHOVEN: Thank you.

Task force members?

Peter Lee?

MR. LEE: A number of us -- and I'm not

appointee of the governor -- who are appointed specifically on the understanding that this task force would add to the process, not take away from it. I'm concerned that this message is taking away from a process that is going on currently in the legislature, needs to go on in the legislature.

I'm very concerned that this task force, I'm very optimistic, will make broad recommendations and inform policy. I hope we will inform the legislature. I hope we will inform the governor and the private sector. But we are not the only game in town. Not just in this state, but the whole health care arena is a moving arena. It's a changing arena. There's always going to be new information that everyone needs to consider. The governor. The legislature.

And I'm very concerned that the process of the legislature is involved in has taken great consideration that on occasion may get started by anecdotes, but I certainly hope that they're informed by patterns of cases. I agree that you can't legislate by anecdotes. But they can start an investigation that can identify patterns that can get a full hearing for appropriate response.

There's a couple issues that -- I mean I certainly expect that task force members have different views on the governor's position. It would be unacceptable to me to have us appear in any way as a body that is hearing on specific pieces of legislation. I

think that is the last thing that we need to do.

It is going to distract us from having a big picture. If we have 84 bills coming before us as "What do you think? Thumbs up or thumbs down," I think that would be the biggest distraction we can have and really deflects us from providing the counsel that we could possibly provide, and I think that we're on a good track to provide it.

I appreciate the letters we've gotten from some of our members on the task force who aren't here. I've possibly noted my concern about this and will communicate directly to the governor, and I encourage all of the members as well. I think the task force needs to, as a task force, though, have a statement that we see ourself as complementary to the legislative process, the dialogues that are ongoing on a number of fronts. And we hope to add to that process and not be a forum to hear specific bills or take views on specific bills.

MS. BOWNE: I second that motion.

DR. ENTHOVEN: Dr. Brad Gilbert.

DR. GILBERT: I think we have a unique opportunity here. I'm medical director for an HMO that happens to be a public entity, nonprofit. One of the Medicare, managed care, HMO's.

We have a unique opportunity on this task force. This is made up of a diverse group of people. It's not industry dominated. I counted about six or seven of us that are directly tied to the HMO. It has consumer

advocates and physicians. But our role should be to provide broad, comprehensive structure for reform of the managed care system.

And I think the thing that disturbs me the most are two comments by Mr. Shapiro. One is there are things being considered in the bills that have nothing to do with us. They're not things specifically addressed by this task force.

Number 2, if I disagree with a given bill, which I may, because I believe it addresses something that I don't think is appropriate, then I do that through the process. I come testify at a hearing. I write a veto request to the governor. I do whatever I feel is appropriate politically in terms of the influence that I or my associations have.

So I would go to the point of the concern about sending a message to me is that decisions are made on the merits in the process and that there is not an action taken by the governor to use this body as some way of thinking that what we'll do is specific enough to make decisions about individual bills. I wholeheartedly agree with Peter, that's not a role to even look at individual bills at all.

So I would be supportive -- and I don't know quite the forum or the vehicle for that -- of us sending, if the task force agrees and believes this is pertinent -- that decisions are made on the merits in the process and that our role is to provide broad, hopefully specific

enough that you can use our recommendations to modify change, create new different legislation.

DR. ENTHOVEN: Dr. Helen Rodriguez-Trias.

MS. RODRIGUEZ-TRIAS: I'm a member of the task force, also as a governor's appointee as a consumer representative. And I'm a member of the women's health council, which is advisory to the office of women's health.

And I think I share the concerns that probably all of us sitting up here share, that we will be used in the way that is not productive or conducive to really supporting a democratic process, and I just wanted to voice that.

I do think -- and I would like to propose that the task force make a very strong statement to the effect that we recognize that our tasks are to address some of the structural and some of the accountability and some of the systems of responsiveness to consumer needs that the health care system ought to have and particularly managed care and not that we are speaking to all the issues and all the concerns but simply to try to structure the governments and the oversight in a way that managed care can continue to develop quality assurance tools and continue to address the health needs much better.

DR. ENTHOVEN: Thank you.

Ms. Maryann O'Sullivan.

MS. SULLIVAN: I wanted to thank you all for coming from the legislature today to focus us on this and

to acknowledge the work that's gone on in the last years to get these bills to where they are. I'm aware of the numbers of hearings and the people that have been involved in the negotiations and the fighting and the compromise. And it's been huge and have taken a lot of commitment.

And for anybody to pretend that we, who just met each other a few months ago and are going to be finished with our work nine months after we started it, have any capacity to do anything like that is to create a charade. We're not capable of that. We don't even know if we can come to a consensus on one single thing. We had trouble getting a consensus on a mission statement.

To say we're going to examine the 85 bills is not possible. So I'm recommending something along the lines of what Peter recommends, is that we -- I think we ought to send some delegation, which includes our chair, to meet with the governor to ask that he simply examine these pieces of legislation on their merits and not pre tend that this task force has the capacity to do that. And really -- I mean in my eyes, he's abdicating a serious responsibility.

There's something else to think about is if we finish on time -- we finish in January -- there's no legislative language -- we're not going to come up with legislative language. So we're talking 1999 maybe before things really started getting introduced. But that's not even -- he says putting it off for four or five months. We're talking about year and a half, two years before

things get considered again.

We should be asking for a meeting with the governor, conveying a statement that says we want him to consider these bills on their merits. And also I'd like to see these items back on our agenda until we feel like it's resolved.

DR. ENTHOVEN: Dr. Barnard Alpert.

DR. ALPERT: With regard to the theme that we're discussing, it seemed to me that Professor Enthoven stated clearly at the beginning that we were given -- correct me if I'm misstating it -- we were given a charge, and it's our mission to accomplish that charge, i.e., to do the business for which we were asked and created.

It's my assumption -- and, from what I'm hearing from everyone else, it's our assumption, those who have spoken -- that other government agencies and branches would also continue to do their business as a public service.

DR. ENTHOVEN: All right. Mark Hiepler.

MR. HIEPLER: I have one idea as a task force we should vote on a issue. I think this is completely a non-partisan thing. The task force should make a statement that we do not feel our role should impede the legislative process in any way. By making that clear a statement that the bills on the merits can win, they can die, they can be veto. But they can be discussed on the merits.

I don't believe any of these bills are

anecdotal related. Specifically, I think they come from problems affecting masses of people. I usually hear from a lot of them. I know where those things. And specific bills, some which I agree and some which I don't agree -- I don't think we should impede the legislative process.

If we make that statement, it allows them to take the regular process and go on and not force us to be in a position where we can't do the things that I think people may perceive that we will be doing. And just as was stated, if we come up with this beautiful plan to solve all of the world's problems, in January there still will be legislation to enact what we're saying. Basically we're behind a year.

So I would move we make a statement that we don't feel it's our role to impede the process of legislation or to hurry it up. But just to do our role and let the legislature do their role. And many people may differ on whether we should send the message. That's just a motion I move so we can get off the topic and move on.

DR. ENTHOVEN: Clark Kerr.

MR. KERR: I think it's important that we have a statement or a resolution or whatever it might be that clarifies what we see, what we are doing, and what we're not doing. And I think it's important that it sends a message along the lines of what we're talking about today and also something we can all agree on since we come from different viewpoints. That may not be

possible to do it in the task force, but we can try.

Maybe we can make a statement for the task force?

DR. ENTHOVEN: Sure.

MR. KERR: Something like the California Managed Health Care Improvement Task Force is established by the California legislature to inform the public, the state legislature and the governor about managed health care and its impact and to make recommendations on ways to improve managed health care for the benefit of the public.

The task force intends to provide the public, the legislature, and the governor with the significant report that specifies recommended actions to improve our California health care system, including structural issues and accountability to the public and to improve the health of Californians.

The task force informs or advises, whichever, the public, the legislature and the governor that we have not been asked and do not intend, as a task force, to comment on individual legislative bills but rather to state our systemic findings and recommendations to help inform both private and public policy development.

Therefore, the task force strongly encourages the public, the legislature, and the governor to engage in an ongoing, constructive dialogue today, as well as tomorrow, about how to best ensure our health care system meets the needs of Californians for high quality,

accessible, affordable health care.

DR. ENTHOVEN: Is that a motion?

We have a request here for you to repeat it.

MS. SULLIVAN: The sentence from "therefore."

MR. KERR: Therefore? The task force informs the public, the legislature, and the governor that we have not been asked and do not intend, as a task force, to comment on individual legislative bills but rather to state our systemic findings and recommendations to help inform both private and public policy development.

MS. SULLIVAN: Thank you.

MR. PEREZ: I'm going to suggest that we will get this language again and maybe come up with a more succinct amendment. It really restates what my colleague Mr. Heipler stated. Basically that the task force make a statement that we do not feel it's our role to impede the legislative process or make specific recommendations on the individual merits of specific proposed legislation.

I think when we get back into a discussion as to what was our charge and what wasn't our charge, we get back to the wonderful meetings that we had several months ago in Sacramento where we wrestled with what our mission statement should be and what our charge should be, and we get away from actually doing the work that we've begun.

The governor has made a statement that he is going to hold off signing legislation until we respond with our report. And I think that that's absolutely an

abuse of the process. And for us to go into great detail about what our charge is really misses the point.

What we need to do here today is specifically respond to what the governor has done and ask him to evaluate issues on their merits and do not allow us to be used in such a way where we're put before the legislature and the governor. If we get into that discussion, I think that we open up a whole other can of worms where we start talking about how the task force is staffed, what role the governor had in selecting who it is that does a lot of the work that leads up to the discussions and the decisions we have.

I think that's something that is going to be extremely unhealthy for us and something that extends the amount of time it would take for us to do the specific actions that we have chosen to undertake. So I would suggest we go back to Mr. Hiepler's comments and make a very brief, one-paragraph statement that we don't intend to be used as a wedge between the legislature and the governor, and we ask him to evaluate issues on the merits.

DR. ENTHOVEN: Dr. Karpf?

DR. KARPF: Mr. Kerr covered most of my sentiments. But I'd like to reinforce the fact that I think what he's trying to do is reinforce our fundamental approach to health care. We have not only a public service to California to provide, but maybe a public service to the nation to provide. And that would be

fundamental changes in accountability. Some fundamental approaches.

None of us, I don't think, signed up to look at specific legislation. I think the more clearly we extricate ourselves from the political legislative process, the better off we are.

So I think whatever statement we write should say that we will stay at a fundamental level and stay away from specifics as much as possible or as completely as possible.

DR. ENTHOVEN: Thank you.

Harry Christie.

MR. CHRISTIE: Mr. Chairman, can you hear me with this thing? After all the conversation and dialogue on this subject, I'd like to offer a consideration for the task force that I think is more succinct than we've heard so far, and that is which follows.

Be it resolved that the Managed Care Improvement Task Force recognize the importance of and fully supports the unimpeded legislative process with regard to managed care bills now under consideration in the California legislature.

DR. ENTHOVEN: Helen Rodriguez-Trias.

MS. RODRIGUEZ-TRIAS: I basically like Clark's approach, as well, to preface this to say we reaffirm the content of our task as to what was contained in the legislation creating us because that's what it is. I think we do have to say something that is along the

lines that we do not want our work and our carrying out our task to be used in any way to impede what should be the democratic legislative process of this state. I think that ought to be very clear because it was fine until there was an explicit statement to the effect that legislation would not be considered. I mean we could do our work because it would proceed. And we've been put in an uncomfortable situation which actually misshapes the work of the task force.

I think it undermines the work of the task force to be put in the situation and as an example of time consumed precious time from serious business the time we spent discussing this item.

MR. SHAPIRO: Mr. Chairman, may I reinforce one element that was stated as part of the potential resolution. I believe there was a comfort factor earlier on when we understood that this body expected the governor to consider legislation on its merits. That could allow the governor to veto bills, which many of you may oppose or not agree with, who allows the legislature to come back and reflect if it is opposed.

That was our understanding, that we had reconciled it. Let the governor and his representatives who are here and others decide whether this legislation is legitimate for public policy. I would encourage that aspect of the resolution to be included to make clear that we're looking at things on the merits, the legislative process is not impeded and this body can get on with the

good work that it was intended.

DR. ENTHOVEN: Okay. Barbara Decker.

MS. DECKER: I liked the concept that Maryann O'Sullivan mentioned of having yourself and various members of the task force go and speak to the governor and his representatives about our role. I think that we could spend another hour today deciding which of these statements is appropriate. Perhaps we could have an easy simple vote that we all agree that we are not part of the legislative process, and we ask that to proceed on its own merits and ask you to take the role of discussing with the governor in more detail the concerns that have been expressed in the last hour.

DR. ENTHOVEN: Maryann O'Sullivan.

MS. SULLIVAN: Thank you, Barbara, for that support. But I don't recommend that alone. I think there needs to be a statement so that by the end of today, everybody is clear where the task force stands. I think a visit to the governor is important. I'm not sure of Sullivan's rules --

DR. ENTHOVEN: I'm not sure either. We have Clark's motion --

MS. SULLIVAN: I would like to add Michael's amendment to it about things are considered on their merits. That language has been discussed all the way through this whole process.

DR. ENTHOVEN: We have Clark's motion on the table and then seconded. And I think that's where we are

in terms of motions. Let me just say one thing about some of the suggestions. I think you'll make it difficult for some of the governor's appointees if you word it very sharply as if we're coming back at the governor in his face and saying "No, no you did the wrong thing." We want you to behave differently." I don't feel it's my responsibility one way or the other to tell the governor what to do.

I think to encourage some of you people in thinking about this to not press the wording to the point that it will reduce our ability to --

MR. SHAPIRO: I was just handed a letter from the governor to legislators saying he will veto all bills --

DR. ENTHOVEN: I haven't had a chance to --

MR. SHAPIRO: Has it been shared with members?

DR. ENTHOVEN: Brad.

DR. GILBERT: In terms of process, Clark, you could consider -- I'm pointed by the governor. I'm not uncomfortable at all about recommending that the legislative process occur, that things are looked at on their merits rather than -- maybe leave out the "rather than" -- but I've heard a lot of people agreed that the process should occur and bills should be looked at on their merits as they always would be in a normal legislative process. If you accept that --

MR. KERR: I think adding one sentence

something to the effect that the task force supports the health legislation be considered on the merits.

DR. ENTHOVEN: John.

MR. PEREZ: I want to make sure that the bill be kept within the language about making sure that the task force not impede the legislative process.

DR. ENTHOVEN: Do you have that in there, Clark?

MR. KERR: I have that it is be considered on its merits.

MR. PEREZ: We need reference to the task force not being used to impede the legislative process.

MR. HIEPLER: What if it's considered by the merits ten years from now? It doesn't do any good for people between now and ten years --

MR. KERR: How about adding that the task force supports health legislation be considered on their merits and the task force should not impede the legislative process.

MR. PEREZ: The task force should not be used to impede the legislative process. A semantic difference, but one thing is we don't impede the legislative process, and another thing is that we not be used as an excuse that impedes the legislative process.

MR. KERR: Can we not use the word "used" and say "not impede"? In other words, I'd rather not say we're being used. We're probably being used by everybody under the sun. But rather acknowledging that everybody

using us and keep that out and say we should not impede the legislative process.

DR. ENTHOVEN: Clark, read it one more time. The clause at issue.

MR. KERR: Therefore, the task force strongly encourages the public, the legislature, and the governor to engage in ongoing constructive dialogue today, as well as tomorrow, about how to best ensure our health care system meets the needs of the Californians for high quality, accessible, affordable health care. The task force supports that health legislation be considered on their are merits, and the task force should not impede the legislative process.

MR. CHRISTIE: The task force must not impede the legislative process.

MS. SULLIVAN: I just want to ask the legislators if they had any recommendations to us on that statement.

MR. LEE: What you want is a statement from the task force so we can move on with our business and you can move on with yours and what we've been trying to do is that. Does this generally meet those needs?

ASSEMBLYWOMAN DAVIS: I think it does. I certainly appreciate the way in which you've approached this. I think I would add in light of the discussion that you've had. I'd be remiss if I did not, on behalf of myself and behalf of Mr. Granlund ask that perhaps the governor reconsider the bills that have already been

vetoed. We would certainly ask for that much.

DR. ENTHOVEN: I think we can trust you to do that. Part of my concern here is trying to be conciliatory about.

MR. PEREZ: Mr. Chairman, where it says the task force not impede the legislative process -- immediately following the word "task force," if we could insert the word "process" again so that the task force process not impede the legislative process. Then it's not a statement of us being used but rather that what happens here not impede legislative process.

MR. KERR: Therefore, the task force strongly encourages the public, the legislature, and the governor to engage in ongoing constructive dialogue today, as well as tomorrow, about how to best ensure a health care system meets the needs of Californians for high quality, accessible, affordable health care. The task force supports that health legislation be considered on their merits, and the task force process should not impede the legislative process.

DR. ENTHOVEN: Second for that?

MR. PEREZ: Second.

DR. ENTHOVEN: All in favor?

MEMBERS: Aye.

DR. ENTHOVEN: Oppose?

ASSEMBLYWOMAN FIGUEROA: Thank you.

ASSEMBLYWOMAN DAVIS: Thank you, members.

MS. SINGH: One announcement. The letter

from the governor that Mr. Shapiro referenced is being copied at this point and will be distributed to you for your own information.

DR. ENTHOVEN: I propose we take a short break for less than ten minutes.

(Whereupon a break was taken.)

DR. ENTHOVEN: The task force will please come to order.

We're briefly going to consider one remaining question that had come up that Maryann O'Sullivan wants to raise. Then we'll move on.

MS. SULLIVAN: I'd like a motion that the task force commit now to sending a delegation to meet with Governor Wilson on this issue to express what was in Clark's motion.

MR. PEREZ: Second.

DR. ENTHOVEN: Okay. Let's go ahead and take a vote on that.

MR. HAUCK: Mr. Chairman, I think we -- it's my feeling we resolved the issue a few minutes ago. And we resolved it in a way that is not aimed at any body or any particular person and in a non-confrontational way and in a way in which we can all agree.

I think we should leave that as it stands and transmit the resolution that we adopted and to all of the appropriate people. The legislature, the governor, the relevant committees, and to any relevant department heads and go on with our business. I think getting into sending

delegations to anybody gets us right back into the kind of situation that we really don't want to be in. At least I would suggest we don't want to be in. And, frankly, it's not likely to change anything, anyway.

DR. ENTHOVEN: Rodney Armstead.

MR. ARMSTEAD: Mr. Chair, I agree with Bill -- sorry if you can't hear me. I'll try to speak up.

The intent here was not for the task force to get engaged and really create -- begin to politicize things, I think we have done our work and moved forward. I think when we begin to meet, we begin to add credibility to an issue that we were trying to extract ourselves from.

I think if we make the statement clearly, it goes forward, we go forward. And I think the delegation begins to engage a political process and discussion around something that is something that we are really trying to distance ourselves from.

So unless there is something else that we're trying to attempt to accomplish, I think that we've been clear, and we should go forward with continuing our work.

DR. ENTHOVEN: Thank you.

Maryann, I'd like to say it makes me very uncomfortable. I'll have to vote against it. What I'm trying to do is keep this thing fairly non-partisan and keep us out of involving ourselves from confronting political figures and so forth. As Rodney says, distancing ourselves from it.

With all due respect, I would personally have

to vote against it, and I'd feel uncomfortable leading such a delegation. If we were, it's almost as though we ought to meet with legislatures and ask why did you create this task force if then you are going to produce 80 bills? I means there's a certain logic to the governor's position.

I appreciate that it's irritating to people who worked hard on doing legislation. But, anyway, I feel very reluctant to be involved in that myself.

MS. SULLIVAN: I think it's about communication. What happened in the last two days isn't just an event that happened in the last two. It affects years of work that hundreds of people have engaged in.

And we've got a statement. And I think that the next step in communication is to face-to-face communicate that statement to -- and I think it is directed to somebody. It's directed to the governor. He said "I'm vetoing these bills without looking at their merits, and we're saying "Please look at their merits." I think it's important. It's basically to complete the process of communication.

MR. HAUCK: Mr. Chairman, I respectfully say that I don't think that's what we did. It's my feeling that the resolution we adopt is not aimed at anyone. And I think that the point the chairman made is relevant. The legislature has had a hand in creating this entity.

And, Michael, I appreciate points that you've made, but we've worked around there long enough to know

that legislatures understand that when they vote for something, it can be used or not used or abused.

I think it's a mistake for us to get ourselves between the legislature and the governor and go beyond what we've already done. And I don't interpret the action as being aimed at anybody in particular. And if it's aimed at the legislative process, that includes the legislature and the governor, and that seems to me to be what we did.

DR. ENTHOVEN: I'd like to go ahead and call for a vote now.

Sorry, Michael. We need to make --

MR. SHAPIRO: May I make one comment?

DR. ENTHOVEN: Briefly.

MR. SHAPIRO: In the letter from member Gallegos and ex-officio member Rosenthal to this body, which is attached to a letter to the governor, they have asked for a meeting with the governor.

In a press conference this morning in Sacramento, they have reiterated that call for a meeting with the governor with a delegation from the task force. You can imagine a way this is political problem, but it's there. And the question is whether you want to implement the resolution you adopted with the clear communication to those members who are seeking a meeting with the governor or do it separately. But I just want to add that that is in the communication was sent to you by the two members of your body.

DR. ENTHOVEN: Thank you very much.

All in favor of the motion would you please raise your hands long enough for our vote counter.

All opposed? 14.

The motion passed. Thank you very much.

MR. LEE: I think that I would strongly support what Bill made that the statement be distributed widely and be sent to the governor, to the legislature. I strongly support it. And it's a great one.

DR. ENTHOVEN: Thank you, Peter.

We will move on to our task force expert resource group. Let me remind you the idea of the group was to designate pairs of people who would particularly focus on some of the very important questions that we face. The reason it's pairs and not larger is because of meeting requirements of law.

However, we very much hope that other people who have ideas to contribute will do so, will contact members of the expert resource groups, speak to them, write to them, giving due care to the requirements of the law or, if necessary, as I think we'll be arranging in at least one phase, going ahead and having a larger meeting, which we will notice and hold it in an appropriate place so that we have a larger meeting that does meet the requirements of law.

One way or another, the point I want to emphasize is these groups are not meant in any way to inhibit other people who have ideas to contribute from

making those contributions. It was just a way of trying to create focal points for -- and to fix responsibility for people to whom we are looking to summarize issues, layout pros and cons and recommend suggestive findings to the task force.

With that, I'd like to go ahead with the next presentation. We've got Kathryn Murrell and Ron Williams to work on the question of ways of streamlining the regulatory process.

The order has been juggled around here. But I guess my latest indication is that the order in which it needs to be done.

Ron.

MR. WILLIAMS: What I would like to do is -- I will try and speak very loudly so that I can be heard.

The topic I'll be covering this morning is regulatory simplification. There are really five categories that I will be speaking about. I view these as really fairly broad and general topics, and I think they should be viewed as starting points for additional input from other members of the task force who I suspect may have contrary points of view.

There are essentially five issues I would like to cover today. And I think these issues should be viewed as broad topics and as starter points for further discussion and input from other members of the task force.

I think the first issue centers around the structural issues Department of Corporations versus

Department of Insurance. The second one will talk about the whole issue of health plan operation and documentation and opportunities for simplification in that area. The third, we'll discuss the medical group oversight in simplification in that area.

The fourth is elimination of audit redundancy. And the fifth is a category that I term the Department of Corporations resources, which retells some of the recent budget discussions that have been held.

In the first, the issue of Department of Corporations versus Department of Insurance. The perspective really is that the historic role of the insurance department is really focusing on financial stability of the insurer and that that is a fundamentally different activity than the role of the Department of Corporations, which really focuses much more on service delivery, on indirectly and directly assessing quality of medical management activities and network accessibility, among other areas. And, therefore, the division between the Department of Corporations and Department of Insurance is used as something that works and that works well. The first point.

The second point is the area of documentation health plan products and operations. I think that one big area for simplification centers around the distinction between health plan amendments or notice of material modifications. And I'll try to describe those.

Essentially, a health plan amendment is used

as a relatively small change in the operation of the health plan with material modifications seeming to be material and substantial. I think an opportunity for improvement is really developing and changing criteria to 28 amendments and material modifications. So that a consistent criteria can be applied both by the staff and by health plans. And this is an area where I think there could be substantial opportunity.

Another opportunity for simplification would permit annual general amendment filings. This would permit health plans to do general housekeeping on non-material changes on an annual basis, as opposed to repetitively filing fairly small changes that take place on a regular basis and would relieve paperwork, we believe, without adversely impacting any consumer issue.

The next issue would be around the timing of amendments and how things work. Let me pause and explain the sequence here. Typically a health plan will submit an amendment requesting a change. Typically if no comment is received within 30 days, then the health plan may typically proceed to implement whatever that change is.

The simplification that that would be an improvement from the point of view of a health plan would be if an amendment is submitted and there is no response within 30 days, and subsequently the department would deem that change to be inappropriate, that the health plan would have to comply, but wouldn't end up subject to disciplinary action as a result of that.

So the health plan would say "We found something. We waited the appropriate amount of time. And if it's deemed to not be appropriate, we can certainly change it consistent with the department's request but that we would respectfully request the disciplinary action be avoided because we didn't know if it was an appropriate thing to do."

In terms of material modifications, I think it would be helpful if notices of material modification would specify when the change described in the material modification could be implemented and if a plan request was termed "expedited treatment" and that request is denied, that the health plan be informed of that within five days of the date the material was filed. A lot of these are procedural issues.

At the end of the day, what the consumer gets out of this, I believe, is continued innovation, continued development of new products, and the development of new kinds of approaches that can result in things that are much more market responsive, things that address some of the types of issues that have come off on the legislative process where health plan says it needs to make a change, and once it files with similar requests, it has to go through this kind of process.

Shifting to the third major category, which would be medical group oversight. I think this is a very important category. I think there are a variety of contractual relationships with medical groups and health

plans where the downstream -- of subcontracting arrangements have added new challenges for state regulators.

What happens and I believe is insufficient is that the financial and consumer protection standards are met solely by the health plan reviewing the medical groups where those medical groups are not already licensed by the Department of Corporations and that there are opportunities for uniformity and equity in audit procedures for medical groups and other provider group entities that there shouldn't be financial and operational audits of such entities.

Also the relationship between the health plan and the medical group may sometimes involve a third party. A medical services organization, independent practice association that actually manages on behalf of the medical group and that regulatory standards need to take that issue into account.

The fourth major area would be elimination of audit redundancy. I think there are substantial opportunities to establish audit standards in the more generally acceptable among state agencies. This would reduce the need for multiple audits and create more uniformity in the audit process.

Particularly related to quality audits, one suggestion would be to deem as approved for state regulatory purposes those plans would meet certain nationally accredited standards such as the NCQA standard

for health plan accreditation.

The final area discusses the Department of Corporations resources. I think there's been discussion and legislative action around supplementing those resources. And I think it's important that in simplifying the process and streamlining the process, those resources be not only enhanced but be accompanied by additional support in the area of additional training for the staff in terms of new and existing staff and helping to ensure consistency and accuracy in the review process.

The DOC staff sometimes finds it difficult to make judgments without concurrence of other peers and frequent additional training to strengthen the confidence of those reviewers in their personal decisions, allowing for more consistent decisions among health plans and overall better oversight and better practices among the health plans.

DR. ENTHOVEN: Do task force members have questions?

Are you go to be writing this up? And we'll distribute it?

Let me ask you about medical group oversight. Essentially now it's all done through the health plans?

MR. WILLIAMS: There are two categories. One would be the medical groups who actually apply for a type of Knox-Keene license. And there is oversight and regulation by the department. There are a wide variety of

other groups who do not addresses the oversight and requirement for many of the consumer issues occurring through the health plans oversight process. There are other categories of provider organizations that also --

DR. ENTHOVEN: Are you saying for those medical groups there should be financial and operational --

MR. WILLIAMS: Yes. I think the point is that in the delivery system today, the medical group has taken on such an important part of the delivery system and that the consumer has many service interactions with that medical group. And I think there needs to be some thought on how best to address those issues.

DR. ENTHOVEN: Would that relate to what the pacific business group on health has done with respect to HEDIS reporting where instead of each health plan contracting a medical group goes and tries to get the information, it's done on a once-and-for all basis through CCHRI? Which makes sense. Is that part of your suggestion? Do this once and for all? So the doctor only sees the inspector once a year?

MR. WILLIAMS: Yes. I think the CCHRI, which would be one good example of where the industries are coming together and conduct chart exams, chart reviews, and quality information for all health plans participating.

There are a host of other reviews, for example, health plan quality audits where for every health

plan that goes through that quality audit, it's not unusual for a medical person to go to that medical group and pull audits. Every health plan in California contacts with that medical group will have personnel from various departments in there periodically going through that. It's another opportunity for a more affordable approach.

DR. ENTHOVEN: Once and for all?

MR. WILLIAMS: Yes.

DR. ENTHOVEN: That sounds promising. With concern about the low medical loss ratios and high administrative costs, it seems like we ought to look at that issue.

Steve.

MR. ZATKIN: It's an ordeal. On the issue of medical group oversight, some work has been done by the previous commissioner corporations and an advisory group looking at some of these issues, and I would recommend that we review it. And I think that it focused on the degree of risk that was being assumed by the entity down the stream. And I did hear you say that your approach would look -- would be based on that; is that correct?

MR. WILLIAMS: Correct.

DR. ENTHOVEN: Ron, did you want to comment?

MR. WILLIAMS: Yes. I think the comment is that a lot of the financial dimensions do focus on that, and I think also there are other consumer issues in efficiency and reducing administrative costs in the system with coordinating some of the quality.

MR. RODGERS: Ron, two questions. Number one, could you address where you see accrediting agents participating in the process in lieu of a, say, a regulatory agency doing it? And, number two, do you feel that if there was a standard approach, it would drive the market towards a common contractual arrangement in that once you standardize the inspection and audit and evaluation, there is a tendency for everyone to start to look the same? So it does take some of the contractual variance out of it. I don't know if that's good or bad. I just see that as a potential consequence of a standard approach with medical groups.

MR. WILLIAMS: On accreditation, I think that there would need to be some process to establish what were the best accreditation service that the regulatory agencies felt met their needs. So I think that's a judgment that they would have to make. I think -- and I know there's been a lot of conversations, for example, between the DHS and Department of Corporations were on some of these issues. So I think it's a process that needs to be worked through.

In terms of your second comment, I think the -- I'm not suggesting common contractural elements in that regard. I'm suggesting that solvency, calculation of claim reserves, that there be certain almost gap-like accounting standards and still leave lots of room for market innovations for different types of arrangements, recognize the different market segments serve their needs

different from consumer segments.

So I think the best analog is someone would need to be looking at solvent times of the county and financial issues.

DR. ENTHOVEN: Mark Hiepler.

MR. HIEPLER: In looking at the risk issue, that's one area where the patients have no idea as to how often the medical group takes on big risks. In Ventura County we've had several go bankrupt. And in order to regulate or look at this issue that you've discussed, do you think it's something that should go through as far as needs of implementation through the Department of Corporations from the HMO down? Or do you think there should be something directed to all non-Knox-Keene licensed IPA's as far as implementing that to make sure that the risk benefit analysis?

MR. WILLIAMS: I think that in most instances that I'm familiar with, the health plans do set the time limit of the individual physicians, providing them very substantial stop-loss coverage. Basically the insurance mechanism assures that the individual physician exposure is limited to what they could safely accommodate. That's an important safeguard in the system that often gets overlooked.

I think in terms of the implementation mechanism, I think that's something that the task force ought to think about. I don't know that I have a clear understanding of the best way to accomplish that.

DR. ENTHOVEN: Bruce Spurlock.

MR. SPURLOCK: Mr. Chair, I appreciate your conversation, and I do want to echo the comments of the chair that producing unnecessary audits of the physician is a key component of what the task force should do.

The studies look like in the average physician office that they go through 14 different audits in one year from different agencies looking at their different functions not just on performance characteristics. So I think simplifying that streamline is an important part.

I'd like to ask you a question about walking through the process that Blue Cross or any health plan might go through when they think about shifting a component of risk onto a medical group, especially when talking about a significant component.

It seems to me that most health plans would go through financial analysis, some kind of performance analysis, before giving 70, 80, 90 percent of the risk onto a medical group. And it strikes me as unusual that we have to have a secondary process from an outside agency on something that the health plan is probably doing on themselves.

It's in the health plan's interest not to have a bankrupt or poor performing medical group in the first place before it happens and that there's some process that you or other health plans must go through in order to ensure that.

MR. WILLIAMS: I think that it's interesting. I would agree with you that we do a certain amount of careful evaluation of medical groups. I think generally one of the things we find a lot of attention on is that we are often unwilling to give as much risk to medical groups as they would like to have.

We recognize it's our role to assume that financial responsibility and that we are the ones who really have the financial resources to absorb the amount of their ability.

As many of you know, when you quote a premium for a particular organization for, say, January of 1998, we are trying to predict what the rate of medical inflation will be between now and 15 months out. We are predicting what kind of epidemics will occur, what kind of social kinds of problems there are going to be. All kinds of issues that can dramatically affect the underlying claim loss.

Before, we would have, first of all, reviewed certain careful level of evaluation and analysis. We are not able to calculate what their incurred and not reported claims are, for example, when they ask the doctor -- and so there's a level of oversight, but you can't operate someone else's enterprise for them.

DR. ENTHOVEN: Brad Gilbert.

DR. GILBERT: Just a little bit on Mark's comment. Yes, we do financial audits for medical groups, and then we adjust how they have to relate those based on

that.

The question is in looking at medical groups -- because I think one of the things we're learning from the task force is how pivotal their role is in all of this. Do you see it from a standard's approach -- from a standard's approach with active regulation at that level or a standard's approach that creates a standard across the industry that then is regulated more by the HMO itself?

So is it that there's a direct regulatory approach from DOC or whoever? Or do you see it more as the development of standards that then the HMO is then responsible for making sure those standards are met?

The second part of this quick -- on DOC you mentioned about resources. What about the type of people that are at DOC? Medical professionals versus lawyers?

MR. WILLIAMS: Well, let me maybe try and answer the first approach. I think market standards of conduct -- we often spend a great deal of time with smaller medical groups, for example, that are privately owned. You want to see the financials, basically someone's personal income tax report. And there's a lot of going back and forth to address. Do you have the right to see it? Or else, alternately, if you can't assess it, you may end up not contracting. Then you get a letter from someone saying we're not treating that small provider carefully because you won't contract with them.

So there's a certain amount of tension you

give and take in getting that. And some kind of standards of conduct that provide a set of expectations for all parties might be helpful.

And your second question?

DR. GILBERT: In looking at the DOC in terms of the regulatory entity, you talked about training for their staff. What about the issue for the right kinds of staff in terms of the predominantly lawyer-based facility versus really having medical professionals on-staff that can look at issues of quality and those kind of things? Is a staff mix involved?

MR. WILLIAMS: I guess I would start out with it really being fundamentally a resource question. And I think the legislature addressed that and provided ample resources. I think I'm less concerned with whether the consulting of physicians are full-time or consultants other than if you want to have the resource to retain people who are familiar, the resources that the department would be given to help to retain and assist that.

I think my experience has been that the people there are very renown and very special, and there aren't enough of them to keep pace with the current market base innovations that we would, say, here in California.

There are all kinds of neo-production managed care in a variety of areas. There are lots of health plans that are innovative in building products and developing new things. And the organization needs

resources to be able to supplement that.

DR. ENTHOVEN: Peter Lee.

MR. LEE: A question and a suggestion for the issues to consider in your group, which is that it relates both to the medical groups and the DOC versus DOI sort of issue is there's a lot of people in California that fall outside of regulated groups, be it they're in medical groups. They may be in self-funded plans. Or they're in PPO's.

There's that large number of people that don't fall anywhere. I'm wondering how you're thinking about doing it and would encourage you to address in particular the -- it is true that if a medical group has a contract with an HMO, the HMO may pass down certain standards, but that same medical group may have other contracts with the PPO or may not.

And a lot of Californians don't fall in clearly any structure right now that provides service, delivery, quality oversight as a medical group if they are in a Knox-Keene licensee. If Blue Cross is some of the exception as a PPO that is in Knox-Keene, but that's not the case for a lot of other PPO's.

MR. WILLIAMS: What I'd be interested in hearing the position from one of the major employers in the room regarding that issue. And, secondly, I think one of the benefits of a quality oriented process focuses on the medical group is that it tends not to necessarily differentiate by funding type relevant to --

MR. LEE: Absolutely.

DR. ENTHOVEN: Yes. Terry Hartshorn.

MR. HARTSHORN: I think on the stability of physicians from a financial standpoint, we do need to take a look at that because we have had bankruptcies over the years. We've had -- as Ron mentioned, doctors or small groups or IPA's want contracts with health plans, and they won't show us financial statements.

So we -- now we've -- PacifiCare, we set a standard. If they won't do that, we won't contract with them. It's not a perfect world out there. Things are changing and moving. We need a principle of financial stability that runs with a level playing field, whether the physician, the IPA, the medical group has 80 percent of its business, whether it's what you consider managed care or vice versa.

Peter said there's a number of doctors that have probably less than 50 percent of their business which culminates care and they're still in some form of fee for service. There still needs to be some regulation or oversight there.

At a higher level the industry is going through such dramatic change, good and bad, that we need to -- as we go through this change, that we try to protect the consumer and the payers -- I call payer the buyer of health care -- the buyers as much as possible because we don't want to have the infrastructure of the system start to fall apart.

And I think that our study in this area should be very diligent. I don't have all the answers, but I think we need to take a close look at the stability of the provider side and how we either regulate or have oversight in that area.

DR. ENTHOVEN: Terry, what's wrong with the idea that since PacifiCare is there in the middle of the solvency requirements that it will stand behind the care of the PacifiCare members even if the medical group -- you're saying, you know, as the medical group becomes insolvent, you're still there to pay for the PacifiCare? Or are you saying the medical group wouldn't be able to function?

MR. HARTSHORN: A little of both because PacifiCare may be one of 20 contracts that a medical group has. So we have stood behind medical groups and IPA's who have gone bankrupt for our members where we still get the benefits on the benefit package that they purchased.

But it's not -- I guess it's the diversity of the marketplace that makes it difficult to put it on just one health plans. If all health plans have substandards -- maybe that's what Ron's suggesting, that we all have certain standards that we are required from the regulatory agencies to make sure we implement a position on the hospital's side.

I'm not limiting my comments to physicians. I think I started that way. There's a number of hospitals that are on the brink of closing doors as well in

California, and we have to make sure that they're going to be available.

It's a very difficult and sensitive issue. We've actually had -- when we denied physicians or we canceled contracts from doctors because of financial stability, we've had lawsuits or had things that -- because now we're taking away their business flow. Well, we can't be -- we have to have some standards that if the health plan or the industry is living within, then these actions can't be taken as long as we're dealing with integrity here.

"Gee, you canceled my contract. I'm going to sue you," and then six months later they're out of business. And we've had that happen not only PacifiCare, but around the industry.

I'm just saying it's something we shouldn't take lightly. We need to study it and come up with some good recommendations.

MR. WILLIAMS: The appropriate thing to say is that from a consumer protection point of view, we would contract and most other health plans wouldn't.

There are competing points of view having to do with networks, having to do with pressure from various other constituencies, and there's no real basis for the health plan other than -- and that's part of the debate here.

DR. ENTHOVEN: Mr. Armstead.

MR. ARMSTEAD: A comment in the area of

getting back to DOC that I would like to throw back to you and have you reconsider.

The one on the audit redundancy, did you give any thought or what was your mind set -- importantly to streamline the audit, but one of the fundamental issues with audits that occur are they are very technical and stovepiped, in my opinion, as you go in to look and say compliance or not compliance or may say technically compliant, what have you.

And the issue is not going in and seeing if someone's rate of how low they're grievance is, is one thing. That's of less protection to the consumer than an entity when you look and focus the audit to the outcomes of how they really deal with that and have used that to improve themselves operationally.

So I think that there are two issues that are about the audit. I agree with the streamline. But certainly the discussion on your comment on the thought that of the need clearly to improve what we do relative to what we're looking at relative audit more the outcome and how that derives back to improvement.

Getting back to the comment, you just hit this on the DOC. I want to challenge you on the issue of resources more than just who is there. The real issue too on the DOC is that I think it can be better serving to the overall process that if there are individuals that are there that understand the context of not seeing what the intent of it is that are medical professionals that are

part of an integrated team that the policy and things that the commissioner puts forward takes on a different light and complexion than has been the tradition of what has been lacking, I think, relative to how DOC is operating from the perspective of, quote, unquote, that type of thing supported by the commissioner.

I think in the resource -- I would like to challenge you back on that, that I think that's a critical issue in the broader vision of things where the DOC really sits if they end up being the root of what we're seeing.

MR. WILLIAMS: I think in terms of what I think of as continuous quality improvement process, I think what you're referencing relative to not just the statistics about grievances but how is it the entity is really using that as feedback to include the level of quality and ultimate outcome.

I think that's a very important issue both from the audit but also as an important issue relative to the kinds of accreditation standards you can see with like the NCQA. But it's simply if you look for careful review of your continuous quality improvement program, how has that information been used to actually have impacted improving quality of care and the level of satisfaction that the members actually receive. There are a couple of ways to get at that issue.

In terms of staffing, I guess that the comment I would go back to is I think resources are critical. I would encourage the department that the teams

and staffing configurations need to be consistent with the change of evolution of health care. And I would defer to the leadership of that department to look at its own staffing needs. But to come back to resource is really a critical issue.

MR. ARMSTEAD: My comment is that I'm just being more candid than you want to be on it today. That hasn't been present. I'm just making a recognition, not making any recommendation that they have to do X but just say "Hey, where is the medical leadership within the Department of Corporations if they're overseeing health services delivery?" That's just an observation.

MR. WILLIAMS: You're entitled your point of view.

DR. ENTHOVEN: Thank you very much. We're going to be coming back to the whole regulatory structure again and again in fact. So thank you very much, Ron. That was very helpful.

The next person I have on the expert resource group on who practices medicine with Dr.'s Alpert and Spurlock.

MR. SPURLOCK: Thank you, Mr. Chair.

Can everybody hear me? Okay. I'll just have to try to speak loudly.

I'm going to start off talking a bit of context of what our expert resource group is charged with doing and the framework with which we work by trying to develop recommendations, and Bernard Alpert will follow me

with a couple of case examples and then highlight some of the recommendations we're making.

Let me say we're definitely a work in progress. We've had several discussions on this topic, and we've had help from Dr. Enthoven's office. There's a lot of input that we're asking the task force and members to give us when we start making more formal recommendations.

Let me talk briefly about how we evolved from the charge, which is looking at the practice of medicine, who should practice to what we really are going to talk about, which is medical necessity and how should we decide what is truly medical necessity. That's the rub of the issue.

We started off with the charge that we were to look at the practice of medicine as it pertains to two arenas. The first one is the legislative arena and mandates and directions that are coming out that this task force is acutely aware of with all the recent events. The second arena as in the HMO medical necessity and decision-making process as it relates to me practice.

Part of it we realize that medical practice is something that happens all the time that actually in studies 75 to 85 percent of health care is self-care and so in fact that medical practice is something we all do, that everyone participates in.

The real issue is when the level of care becomes complex enough to require higher level of

expertise. And it was our clear understanding that only medical professionals, the people who are licensed and authorized by agencies and ultimately by society to practice because of their expertise in training, should be the ones would are practicing medicine.

It became not so much as idea of who should be practicing but where is the issue when we talk about disagreements about different practitioners. And some of the disagreements happen in what is medically necessary. Some of this happens at the bedside, and some of it happens in the legislature. Where does the process break down?

What we're going to talking about in our solutions and recommendations is a process oriented mechanism by which we look at making care better and decreasing amount of disagreement over medical necessity. We will always have medical disagreement, and we'll have ideas at the end that dovetail into the dispute resolution expert resource group. There will be overlap in our two areas.

But our goal is to decrease the disagreement and to look at process oriented solutions to how medical necessity has actually determined in our industry.

The theme of what we're going to be looking at is really resolving around improving decision quality. That's the theme. And that's the kind of words and message I'd like to have people take away is how do we improve decision quality?

First of all, it's clear from research in the literature that we have a lot of unwanted variation, a variation in terms of multiple procedures, and that variation is a difference in perspective and different people who are practicing medicine.

Dr. Wenberg in the Dartmouth Atlas has highlighted this in the small area of variation. And a California example would be that cardiac procedures in Pomona and Sacramento, California where I live are five times more likely than in Oakland, California. And when you try to dig down in finding out what are the determinants that are deriving that variation, it doesn't seem to be a biological basis or anything that can be determined. Right off the bat, why there's a five-time variation in cardiac procedure.

So there's a difference of opinion how much is done and who should be doing it. And our goal is to decrease that variation so we have less disagreement over medical necessity. The key component to that is where it exists, although it doesn't exist everywhere, is to use evidence-based outcomes that are deriving guidelines that are using input from all of the state holders.

The guidelines must being developed and validated and that's a key area we found is not happening right now. There's a lot guidelines and development, and we don't need more guidelines. What we need is validations of the guidelines and care processes and simple pathways actually improving care and decreased

variation. That's the critical piece that's missing.

The second thing that's important is to incorporate. These are basically the principles of decreasing disagreement and improving decision quality is incorporating the patient preferences in values in the process explicitly, not only at the bedside, at the patient-physician interaction, but throughout the process.

Whenever guidelines and other recommendations about care and medical necessity are made, that a consumer or perspective from the patient needs to be in that process the entire time and make it explicit.

The third principle we're looking at is decentralizing decision making because at it's best, when individualized, it's one thing to make a broad guideline, it's another thing to apply it to an individual because individuals have biologic variations that are important. And we think it needs to be taken into consideration. That doesn't mean there's not a role for central components. We'll talk about that in a moment.

Finally, I think it's important, whenever we look at medical necessity, that we have a thorough understanding of all the relevant information. It's just a good practice of medicine that you have all of the data and you know all of the important factors before going forward. And sometimes that slows the process down. But that's important in improving the decision quality.

The subheading of understanding relevant information is the point that came up with the fact that

self-care is not a necessary medical practice that we're talking about in medical expert resource group. That's that the more complex the care and more complex the medical decision making that needs to go on, the more the expertise required.

You can have levels of expertise that are appropriate at levels of complexity. And as you get up to levels of complexity the levels of expertise and the licensing and authority must increase along with that.

Finally from my perspective, we're looking at something that overlapped in what's happening in the next resource group on dispute resolution with a tiered process of dispute resolution. We both feel it's important that those disagreements are resolved with the patient-physician level. That's where most occur. We think that process can be improved.

The other thing is that patients need to have recourse outside of their physician because of the lack of expert in the medical decision making and should have redress in medical groups within health plans ultimately with a neutral body. But that the overarching entity that derives medical necessity and is evidence-based outcomes that are driven in quality in guidelines that have been validated. And that really is the science and the practice of medicine that really is overarching that really decides what is medically necessary.

We understand there's disagreements about

which guideline should happen. And the more we have outcomes and evidence, the less disagreement about which guideline makes sense. That's a natural evolution of medicine. We don't have to stop at that process just because we have disagreements at this current state.

With that, the overarching themes are laid out, I'll pass it off to Bud and have him talk about specific case examples with medical necessity.

DR. ALPERT: Can you hear?

So the problem is how do you get your arms around this issue of quality in the medical decision-making process. And then how do we, as a task force, translate that into identifying some specific areas that lend themselves to specific recommendations for improvement, areas that we have identified either s confusion or ambiguity or inconsistency. And what we'd like to do is present two such areas, to present our observations based on current examples, and then make recommendations based on that analysis.

The first area is that of government structure. Now, before I give you the example, I remind everyone that when asked to prioritize recommendations to this task force as to how to make managed care work, that is keep costs down while maintaining high degree of participant satisfaction, Margaret Stanley, the CALPERS representative and spokesperson, stated without hesitation her priority number one recommendation was to have accountability into any recommendation we made.

Now to the example that I think highlights this problem of inconsistency or confusion or ambiguity in the area of government structure. An example I use here is a Arizona appeals court decision that was handed down two weeks ago. I'm going to quickly summarize the case and then read from some of the decision because I think it points out kinds of things we're talking about.

The Arizona Court of Appeals judges ruled unanimously that Dr. X, who was a medical record of HMO can be held accountable for his decision that a surgery was medically -- was not medically necessary for a policy holder.

Now, background in the case is that a surgeon taking care of a patient recommended a certain operation. The records -- not the patient, but the records were reviewed by the medical director of the insurer, the plan, and that that surgery was determined to be unnecessary. Subsequently, two complaints were filed to regulatory agencies. The patient filed a complaint with the regulatory agency of the HMO's which was the Department of Insurance in Arizona.

The physician who proposed the surgery filed a complaint with the state board of medical examiners against the medical director in that that was a medical decision. The Department of Insurance dismissed the complaint, finding no problems. The board of medical examiners found against the medical -- said that it wasn't a medical decision and disciplined the license of the

medical director. The same complaint issued with two separate regulatory agencies decided totally 180 degrees apart.

Now, the reason it got to the courts was the medical director of the insurer took the case to the courts at which time this court of appeals said unanimously that the medical director can be held accountable for the decision that the surgery was not medically necessary for policy holder.

I'd like to share with you some specific text from the judgment because I think it's instructive in pointing out this ambiguity. Although Dr. X is not engaged in the traditional -- this is referring to the medical record -- although Dr. X is not engaged in traditional practice of medicine, to the extent that he renders medical decisions, this conduct is reviewable by the board of medical examiners. The patient's physicians diagnosed a medical condition and proposed a non-experimental course of treatment. Dr. X substituted his medical judgment for theirs and determined that the surgery was, quote, unquote not medically necessary. There is no other way to characterize Dr. X's decision as it was a medical decision.

Dr. X is not a provider of insurance. Instead, Dr. X is an employee who makes medical decisions for his employer on whether such surgeries are non-experimental procedure are medically necessary.

Such decisions are not insurance decisions

but rather medical decisions because it required Dr. X to determine whether a procedure is appropriate for symptoms and diagnosis of a condition, whether it is to be provided for the diagnosis, and whether it is in accordance with the standards of good medical practice in Arizona.

So what we have here is an interpretation of inconsistency at the regulatory level regarding medical decision making specifically relating to the standards to which the decision makers are held.

Now, as we have a parallel regulatory structure in California, and as a traditional amount of medical decision making by a physician caring directly for one patient has clearly changed, we believe and recommend that all parties making medical decisions, whether by the traditional direct contact group or by other more removed mothers that nevertheless have direct impact on a patient's medical care, that all such parties should be held accountable to the same standards, and they should be similarly held.

A corollary of that recommendation is that in the government oversight of this area, that the quality of medical decision making in health care delivery also be consistent in its standard and not ambiguous or divided, as illustrated in this landmark decision in Arizona.

The second area that we identified where this confusion and maybe law of unintended consequences has evolved in the system has to do with the area of

authorization and utilization review. Now, in the course of development of managed care, a number of principles and processes have evolved to orchestrate patient care in a great cost effective, efficient and qualitatively desirable manner. I think we can isolate it.

Precredentialing the providers, improved benefit language, retrospective utilization review -- done 20 times more hysterectomies than the other people. We should look at that -- practice guidelines, clinical pathways, and outcomes based research. All great laudable, valid things to improve quality of care to keep costs down.

However, there's one process that is widely practiced, and it's called most commonly the "preauthorization process," which actually is better termed "concurrent authorization" because it actually inserts the bureaucratic process directly into the system after physician-patient interaction has begun.

And this, by the way, is my answer to the question I keep asking about why is everybody upset out there. It's my belief that this is precisely the place that is the cause of the uproar that we've had. This is the place where delays, denials, arguments, other procedures and obstructions are occurring, causing angst and interference with the physician-patient relationship after the patient has sought care for a specific problem.

Sometimes an undesirable medical outcome actually results just because there was an insertion of

this bureaucratic process at this particular point in care. One case example here, a woman has three fingers amputated and has them reattached. This is very common for those patients who have stiff digits after that. They require a secondary operation to take a hand that essentially useless to a hand that can move.

To do that, the surgeon got preauthorization to do a procedure to get the movement, do the operation. A absolute inextricably linked part of that process is hand therapy afterwards very acutely to maintain the motion that's gained. Otherwise, the hand freezes.

In this particular case, surgery was authorized. The surgery was done. The hand therapy was ordered. Two weeks later when the patient came back to the office, she came back with her hand frozen exactly as it was before the operation. No result. The question what happened? "I went to hand therapy. They checked, and there had been no preauthorization for the hand therapy. So they said I couldn't have it. So I went home and kept my next appointment to have the stitches out."

The time interval which was critical in that miscommunication -- and there really are no stones being thrown here as to where it was, with the exception it was the insertion of the requirement at that bureaucratic concurrent authorization that ultimately led to poor medicine and a bad outcome in this particular patient. So its the insertion of the process at that time after the interactions occurred.

The existence of this concurrent authorization requirement or possibly even better referred to as "redundant authorization," why it is the cracks to which patients fall, as we've seen it.

In contrast, precredentialing providers and post-utilization review of practice are quite effective. They don't interfere with care as it's being given. Therefore, we recommend that where it's come to be known as "preauthorization" and the "preauthorization process" should either be, one, eliminated or, two, modified to utilize available electronic technology to document the patient with problem X has a policy that covers it, that it's being treated by Dr. Y, who has been precredentialed by the plan to cover this area of condition. This way plans will be utilizing precredentialing, post-utilization review, practice guidelines, clinical pathways, and outcome status to provide good quality care without widening those cracks which patients may fall.

Those are two recommendations with regard to care and quality to the consumer.

DR. ENTHOVEN: That's really interesting. Thank you.

DR. GILBERT: Couple of questions. One is in terms of the whole -- in terms of the issue of evidence using evidence-based outcomes, how do you deal with the issue of therapies that are moving from or are in experimental or moving just out of experimental where there aren't the studies there that are in the department

necessary which really have those guidelines, which to me is one of the major issues out of managed care concerns.

The biggest issue I have is related to Dr. Alpert's. If, Bruce, you believe that there's inconsistency, your statement of inconsistency or variability -- unwanted variability in decision making, do you differentiate in terms of the whole preauthorization review process between that primary care level initial decision making to go on to specialty care, which it seems to me is potentially more amenable if done right to a preauthorization process versus your example which relates back to your comment that the specialty level where the expertise or the highest level of specialty care in your continuing therapy and your decision making within that specialty, do you differentiate between those two? Because you can't have it both ways.

You can't reduce the unwanted variability in terms of some initial decision making without developing guidelines and processes that help physicians relate to those guidelines. I think your example -- you had a lot of discussion and comments from presenters about the specialty referrals and within specialty decision making. To me that's actually easier to think about in terms of really opening it up and making it simpler versus the desire to try to reduce variabilities that occur when you have primary care physicians with very different levels of training, even if precredentialed, different levels of expertise -- internal medicine versus pediatrician versus

chiropractic -- how do you deal with those tensions?

MR. SPURLOCK: First there was a question on experimental therapies, and then there's a second question on preauthorization at the primary care level versus within subspecialty areas; is that correct?

DR. GILBERT: Taking into account if physicians truly issue using the evidence based on outcomes all the time, but what we've heard over and over which I believe is that they're busy, don't have time to keep up in every field possible and, therefore, sometimes make decisions that the use of guidelines or an authorization process could perhaps reduce the unwanted variable.

MR. SPURLOCK: First on experimental therapies, we discussed this topic about it, and it's actually not unique managed care. Experimental therapy is when they're covered is an insurance issue that's gone on from time immemorial. When do you declare something experimental, and when is it standard of care is an issue and a rub that will continue to exist whether we have managed care, indemnity care, whatever.

So it's not unique to managed -- what's medically necessary and highlighted that is maybe on a more focal point because people disagree on whether that's medically necessary. I think that's going to be an ongoing problem.

So we don't have a specific solution on experimental therapies to this point, but it does fit in

the decision quality process and the framework that we've put out thee.

Let me talk about preauthorization, vis-a-vis, primary care versus subspecialty with respect to decrease in practice variation that I described earlier. One of the difficulties is -- and the tensions that will continue to exist that won't be solved in this task force or really in the near future -- is the difference between being population oriented and being individual oriented.

When you have individual decision with a patient at the bedside, it's challenging to not take those individual variations into consideration in making the decision. Yet guidelines and decisions by medical directors of medical groups or others are population based and that those decisions are removed from that individual process that goes on with the patient at the bedside.

That's the challenging area that we have, whatever structure we come up with to try to solve. Many of my colleagues have joined medical groups for the same thing that Bud was talking about, that they don't have layers of preauthorization inserted into the medical group because the medical group works as a whole and takes risk. They don't even decide whether they go to specialties or not.

They have primary care folks in the group and a multi-specialty group with subspecialties as well, and that decision making is looked at post-hop --

post-utilization pattern. And that happens within that. Therefore, you can decrease variation once you have good information on a population based on a pattern base rather than on an individual.

As long as we continue to look at the individual level and try to throw population-based analysis into the individual decision making, we're going to have tension and problems. So our suggestion is to decrease that insertion as much as possible to go forward with the notion that population-based guidelines have to happen, that they're an improvement that will decrease population-based variation. If we look at it that way, there would be individual variation that should be allowed for because there's biologic and diversity and preference variation that we should encourage and promote.

The notion we have to have multiple layers of authorization, whether at the primary care level or specialty level is the mistake of putting all these preauthorizations. You look at patterns in the global context and what the patterns are.

DR. GILBERT: One clarification. Most of the utilization management necessity decisions are made at the medical group and IPA level by IPA medical director. It's true that some of the very sophisticated multiple specialty medical groups do do determinations in a committee or group sense. But in most network-based HMO's, which is the vast majority in California, according to the California Association of Health Plans, it's a

medical director at the IPA or medical group who is actually making the medical necessary decisions.

So how do you put those two together?

DR. ALPERT: I'll address the last one first. The first example, the Arizona case, it's not so simple. The medical director is someone who is not an expertise in every phase of medicine. As you pointed out, and I think you identified a good idea, that there's a huge difference between the personal line care and specialty care. And so forth.

So maybe for the personal line care, that's fine. For the specialty care, the medical director may have a little additional knowledge than an HMO director does. And we see that kind of thing.

It leads me back to your first question. Today's experimental care is tomorrow's cure for cancer. So that's always going to be there. And that's going to be part of the gray zone that you do have to have people with high levels of expertise deliberating -- should they have the care -- at all levels as indicated and so forth. Eventually that's not an permit any more you have data.

You've done a good thing in identifying the two-layered thing between primary care and specialty care, for lack of a better way to say it. That might be what we recommend. But if we did nothing but recommend removing this impediment where I think a lot of the noise is coming from in the specialty care -- just think. Every operation done in America every day is specialty care. It's not a

small amount of stuff that's going on. It's a huge improvement. And anything we do that can move in that direction incrementally, I think --

DR. ENTHOVEN: You're not worried about destroying lifeguard HMO? The call we had from doctor -- presenting that they worked on preauthorization basis. Some of their doctors get a gold card because they have good track records. But others get free review. Do you recall the example he gave where two women -- their gynecologists wanted to do the hysterectomies --

DR. ALPERT: Two parts to the answer. The first one is simple. No, I'm not worried about them. Number 2 --

DR. ENTHOVEN: Because --

DR. ALPERT: I --

DR. ENTHOVEN: -- don't want to drive them out of business.

DR. ALPERT: No, I don't think you will.

I was impressed with Dr. Hughes' presentation. And what he identified was a problem in the system of the physicians and how they were dealing with the patients. And I would say -- and, again, these are anecdotes. And we try to legislate on the anecdotes, but we shouldn't.

But all of the other things I pointed out, those five or six things -- precredentialing, practice guidelines, clinical pathways, outcomes-based research. We had a wonderful presentation about how we need to

disseminate all the information. That ought to be happening. But the fact it was missed shouldn't be a reason to insert something I think is a major cause of the --

DR. GILBERT: It would have followed she would have had the hysterectomy if she didn't have the review.

DR. ALPERT: Let me put it a different way. When we deal with anecdotes, one of the things happening and the way the task force has worked in public hearings is someone comes to the microphone and says the equivalent of "I bought a car, and the breaks didn't work, and I'm upset about it." And I don't have a cure for the whole thing, but I'm upset about that.

And then we sometimes say, you know, we don't erase the work. We need recommendations about how to hear the whole thing. And, besides, I bought a car, and the breaks did work, which is meaningless.

MR. SPURLOCK: One thing for sure is our supposition is not that we want to place limits on physicians. I think that a lot of variation that's pointed out in the Dartmouth Atlas comes from decision making and physician direction and that physicians need guidelines and limits.

But the process of how you do it and when you do is the critical feature. And if you do it at the bedside on case by case basis, you're making a mistake. If you do it from the pattern basis, which actually

Lifeguard talked about. They had a doctor whose patterns were bad from the perspective of unwanted variation.

You could take the individual on a case-by-case basis, but you don't make decisions at the the bedside unless there's danger to the patient and a bad physician. Then we have a whole stretch with the medical board.

But the whole goal is to look at patterns instead of making individual decisions at the time when it is least appropriate.

DR. ENTHOVEN: John Ramey.

MR. RAMEY: I think I should probably preface my question by saying I'm not an M.D. But I talked to a few. And I think that my question has to do with the survival of fee for service medicine and that there is a role of managed care in the fee for service world. And they -- I think that the research is abundant that there have been a lot of cases of over-utilization under fee-for-service medicine.

And the response of managed care to that has been preauthorization. And the kinds of things that I hear you talking about in terms of the appropriate means to encourage best practices like outcomes and clinical pathways and those things seem to work a lot better in a group -- physician group setting than it would in a fee-for-service environment.

And so my question to you is, aren't you concerned that the prohibition, if you will, on

preauthorization based for individual procedures are not -- are not you concerned that that prohibition would make fee-for-service medicine just completely uncompetitive from a cost standpoint because of the danger of over-utilization in that environment?

DR. ALPERT: I'm not because I practice in this environment every day, and I see what precredentialed procedures are, and I see what utilization review procedures are, and I see what's happening to clinical pathways and practice guidelines. And there's a lot of stuff and a lot more coming down the road in terms of deficiency of dissemination of information.

I really don't. I see, as I balance the two of these, what I see are lots of bills being passed in the legislature. We had a whole thing this morning. That really -- the number of laws we pass giving us medical care via the legislature simply reflects a failure of the system -- the medical health care delivery system to take care of all these things. They're borne out of frustration in the populace but then else -- when it gets to the legislature.

I think that, as I look at what's going on, I think this is one of the biggest sources of the ground swell of frustration we're seeing. And I think enough of the good policies have been identified that rein in or control or guide or shepherd or whatever you want to use, the practice and the physician practicing that at some point when you credential me and say "We've reviewed your

CV and what you did last year. We know where you went to school, what your grade was, so forth, that we're going to let you take care of these physicians," that when you then send the patient with a policy that you gave them as that condition to me, you'll let me take care of it, and then review it again at the end.

DR. ENTHOVEN: Bill Hauk.

MR. HAUCK: Back to what you said, I'm not sure I understood it --

You can't hear?

You're saying that the physician at the bedside should provide treatment based on patterns and not what he sees in front of him?

MR. SPURLOCK: I apologize if I've been unclear on what I'm talking about. I think that the physician at the bedside is in the best position understand all of the necessary components that produce wanted variation, biologic variation, preference-based variation, other variations that we desire in the systems that we should have because we're not all the same people.

When you take that decision making away in putting in the broader context of patterns, then you're looking at what you do with guideline development or process development or decision quality. You look at how decisions were made and not -- to see individual decisions per se because that is not in the purview of population-based decision making. That's what I'm getting

at.

So the pattern of care is something you do away from the bedside. A physician used patterns based on clinical expertise. But the pattern of what the physician is doing, you do away from that individual decision by the medical director by -- on individual patients that individual physicians that have relationships with HMO's, by the medical director of the HMO. But it's not that the pattern of care for multiple patients that we should be -- that we can look at. But we should not be looking at individual patients.

DR. ENTHOVEN: Bill Hauk.

MR. HAUCK: You don't want to constrain the doc at the bedside; is that correct? You want to look at him after the fact, what the patterns of the decisions were?

DR. ALPERT: As a matter of fact what we ought to do is take everyone who is working at a doctor's office now at the end of the preauthorizations and everyone at the insurance companies dealing with preauthorizations. Take them all and put them in the utilization review process at the end. Then it wouldn't interfere with the care. And immediately when somebody exceeded the quotas of hysterectomies or whatever the utilization rendered that you're concerned about happened, you would know about it.

MR. SPURLOCK: Let me make another example. In the area of angioplasty -- we had testimony about a

month ago about the study that was in New England Journal about the number of angioplasties that a cardiologist has to perform that looks at a break-off between outcomes. If you provide more than 70 angioplasties a year, the mortality and complication rate is far less than if you provided less than 70. That's an easy tool by which to precredential cardiologists. And it's outcome-based and evidence-based, and a well designed study.

And that's the kind of thing that we think should be used to look at cardiologists being approved for angioplasty and not on individual case that happens to be at that time. There may be other parameters you might want to look at that put stakes around unwanted variation. But that's one example of precredentialing.

DR. ENTHOVEN: Ellen Severoni.

MR. SEVERONI: I want to go back to the case of the woman with the hand because you see that as a problem with the authorization process. And I think it may well be. But by the same token, I've worked in fee-for-service for many years before we moved into managed care.

And that story just sounds very familiar to me. It seems that woman left her doctor's office without knowing exactly what she was to do over the next couple of weeks. So regardless of what kind of system she was in, had she left with the right information about how to take care of her hand, she would have known, once she got refused there at the physical therapy site, to call that

doctor immediately or whomever the doctor may have designated as the next piece.

I still think that we have so many patients who are not hearing from their doctors what the next steps are as they move through the next process. At CHD we have a lot of focus group information that tells you that patients expect to get that information from physicians about how to navigate the system if there's a problem, who to call, and they don't get it.

And our focus groups with physicians, they tell us that they really don't think it's their job to provide that kind of information, that it should be the office staff.

I think something that we may want to consider here is how do we align expectations between the patients and the physicians? I bet you could cut down on those kind of incidences.

DR. ALPERT: Everything you said in terms of how the process should work is true. I think if we can identify where the frustration is, we might get more of this patient-doctor interaction. You might improve that relationship.

In the example, it was a very educated patient. It happened to be -- and this is individual variation -- it happened to be a trusting person who accepts what the medical industry tells her. So when she -- she knew she was supposed to have it. But when they told her it wasn't preauthorized, "Oh my health plan

doesn't cover it? That's it." There's a lot of individual variation.

Doctors talking to patients in an unrushed, unhurried fashion is what we're looking for, to be able to talk openly to people about what the problem is. And it's an argument for, I think, what the point was. Don't insert the other stuff that are the guidelines or the big brother concepts right in the middle when the doctor is taking care of the patient. Let that part go. Review the blazes out of it on both sides.

DR. ENTHOVEN: Ron Williams.

MR. WILLIAMS: I have a question about clarity. In the HMO world and most of the large HMO's here in California -- delegate to the medical groups and the IPA's clinical decision making. And in your example of the Arizona example, there's a HMO medical director. And I think there's an impression that the health plan -- that has a medical director is making a decision about that particular patient's activity.

In reality here in California, it is a physician's under clinical leadership of that medical group working in consultation with the referral specialist. And it seems to me that your comment is mostly about the government's process or clinical decision-making process within the medical group as opposed to within the HMO. Help me if I'm not getting it right.

MR. SPURLOCK: That's an accurate statement.

The one caveat is that not all the physicians are in medical groups, and not all decisions are shunted down to the medical group.

And it goes back to what I asked earlier, when you look at a health plan giving risk to a medical group and, hence, clinical care to a medical group, how much do you give, and what do you give, and what criteria do you use.

There are individual physicians who contract directly with health plans. There are other places that contract with small medical groups that don't have decision-making authority over these kinds of decisions. So the medical director at some health plans make a number of decisions. We don't necessarily think that's different than the medical director at medical group or IPA making a medical decision.

We talked about tiered resolutions process. We think you should go within that group when that it exists. So you start with the physician and physician and patient, for example. Then you go to the patient and health plan and your medical group when that exists and then the patient and health plan. So you have a tiered response to disagreement over medical necessities.

And you should have some kind of grievance process or communication process within the medical group and IPA when that is the correct decision of that step. But that doesn't happen with every different case and every physician and every disagreement.

DR. ALPERT: This is the end of the game. At both levels there are two issues. One was where was the medical decision made. And the Arizona case there was a doctor who wanted to operate and did consult and work with the doctor representing the carrier. And ultimately the doctor representing the carrier prevailed. That was a decision.

One says should have surgery. The other one says shouldn't have surgery. The one that said shouldn't have surgery had the bigger stick and won. The second issue had to do with the corollary we talked about, was the ambiguity and inconsistency, whatever -- however you look at it, it's called inconsistency. In regulatory structured view of the same incident, one said no problem. One said big problem. And what we're looking for there is simply consistency in the standards used at the regulatory process, as well as all of the people making medical decisions being held to the same medical policy.

DR. ENTHOVEN: Thank you very much. I think we must move on.

Now our next expert resource group is the dispute resolution.

MR. LEE: We ask that the group talk about cases, but we switched the order. We would like to start by having a couple people speak about what happens when the system works and what happens when it doesn't. I'm not sure what our schedule is. We can do that for half hour and then come back.

MR. LEE: What we'll do is a two-part presentation. The first part is to have two people make brief presentations within 15 minutes with questions from the panel. And followed by Barbara and I noting where we are in our process some of the elements and some of the recommendations we are considering making to the task force. Many of the issues we talked about track the issues we've just heard about from the practice of medicine group.

The first is a philosophical point that we think the vast majority of the problems should be resolved at the lowest possible level, which is the doctor's office. And the other at the farthest other end is that grievance type problems should inform quality improvement overall. We have a lot of steps in between.

To frame this now first is Tom Guyser. Tom is the executive vice-president, general counsel at Wellpointe. He'll talk about from the health plan, how do they use the disputes resolution process, how it works. We heard a lot of different points in our task forces' activities from some of the regulatory bodies. The vast majority of issues don't hit regulatory bodies. They don't hit health plans. They hit doctor's offices first.

But we want to give a picture of what happened from the health plan's perspective. Tom will talk for ten minutes or so followed by Harry Christie, who is an alternate on our task force, to talk about what happens when the system breaks down. Different windows on

the dispute resolution issue to be followed by questions, and Barbara and I will do on.

MR. GUYSER: Mr. Chairman and representatives of the task force, thank you for having us here.

MR. LEE: Put the mic closer to you.

MR. GUYSER: Mr. Chairman and members of the task force. Thank you for having us here. We to take this opportunity to outline for you basically the dispute resolution process that's in effect at our principle operating company, Blue Cross of California. And there's three elements that I think you ought to think about when I think about in looking at the dispute resolution process.

The first is how the disputes, disagreements, problems come to the attention of the plan. And as you know, these are very large animals serving millions of people. How do the people get a complaint to the plan, how does the -- how does it get the plan's attention, and how does the plan address the member's point of view or issue?

If the disputes can't be revolved by mutual agreement between the plan and the member, what is the method for third-party intervention? Because this is America in the 20th Century. There's a lot of third-party involvement in dispute resolution between parties that can't come to an agreement.

Last -- and importantly -- is what is the feedback loop that's inside the plan so that the plan --

the people inside the plan dealing with this, addressing disputes, are systematically looking at the kind of disputes that come up and feeding them back appropriately into the plan's governing body to make sure that their systemic issues are dealt.

Inside Blue Cross basically a member or enrollee problems with any variety of things, eligibility claims, nature of benefits, the member is directed with -- disclosure document to call a customer service representative. And there's an 800 number. A person calls the service representative and can either register the grievance over the phone, which the customer service representative takes the grievance over the phone, or can request the form, fill out the form, and send it in.

The earlier discussion about medical groups -- when there's arrangement where a delegation occurs to a medical group, there's additional step where the evidence it covers -- it applies to one third of our membership that are covered by participating medical group, says that if your care is being arranged for by a participating medical group, you have a problem, please contact their coordinator. And if you're dissatisfied with the response of that coordinator, then contact us.

So you can see there's an additional leg on this stool that you know has an impact on timing of dispute resolution and impact on coordination. You have more people that need to talk to each other and facts to be elicited in order to resolve issues that arise.

The plan resolves all -- acknowledges all grievances in writing, and all of them get reviewed. And they're categorized as either urgent or priority. Urgent are those involving serious, imminent threat to the health of the patient -- this is by statute -- such as but not limited to potential loss of life or loss of major bodily function. In short, when something is really serious, it's got to be addressed quickly so there isn't a major potential adverse impact to the member's life.

Response is required within five days to that kind of a grievance. And in the case of urgent grievance, the customer service people are directed to fill out their form immediately while the member is on the phone. The deal is don't let them hang up. Get the grievance and get that underway.

Other grievances -- the priority grievances are to be responded to within 30 days.

There is also an overlay of the Department of Corporation's 800 number, which the member is directed in materials to call at any time during this process. And the DOC in this process initiates their request for assistance process, which in our experience, has been a proactive process, either from the ranges -- on one end of the range is "Please pay attention to this grievance." The other end of the range is "We want you to pay this claim."

I will say from experience from this process, one of the key items of this is the very thorough research

and ability to elicit the facts. The doctor-patient, the doctor-hospital, and patient relationships are complicated ones. They're lots of moving parts. You go to the hospital. You get a lot of bills from a lot of people, many of whom you never saw or can't understand.

People have a hard time understanding that, when there's disagreement, figuring out who's done what to whom is a big job. And it requires people -- one, knowledgeable people evaluating that stuff; two, members who are frequently frustrated, angry, et cetera, bad things have happened to them, making sure that they understand what has to happen and help us in getting the information required to resolved the dispute.

Now, if the member is still dissatisfied after the plan's active grievance or if for whatever reason no decision has been forthcoming to a member within 60 days, the member is entitled to go to third-party resolution, which in the case of Blue Cross is binding arbitration administered by the American Arbitration Administration.

Our experience with this is good, not only from Blue Cross' standpoint for the members, that binding arbitration administered by a third party, the Triple A, which is the most prevalent independent, unpartial administrator of these dispute resolution mechanisms, is that the theory is it's more rapid, independently impartial, and it gives a member a more rapid and less complex form in which to deal with as opposed to going to

the court system, which I don't think many people characterize -- it's not characterized by its rapidity of action.

What happens inside the company, when an arbitration request is received, it goes to the legal department. They have a set of processes that we've evolved over time that, one, are designed to ensure that all of the internal avenues, both administratively and medically inside the company, have been followed.

In other words, we look at it. It's evaluated. And we make sure that every administrative person that may have touched it has done what it should have done. We read the evidence covered language. We try to discern the facts and go back inside the company and say "What really happened here?" And many times this resolves the matter. As part of the first internal processes also, "Have we exhausted all of the medical avenues inside of the company?" "If it has been reviewed by a medical consultant and there's a question involved, should we get another independent medical consultant in to look at it?" And we frequently recommend that that be done, and it is in fact done.

Experience here is it's frequently good to find a specialist located in a discontinuous geography, somebody that doesn't have a financial interest with us one way or the other, someone that doesn't have buddies in the system or what have you that is beyond reproach in terms of a consulting resource.

And, second, part of our theory here, again, is the internal exhaustion of avenues internally. And, second, we want to make sure that the member understands what we're doing. The fact is that not all medical services are covered. And that's just a reality. The nature of these benefits is such that not every single thing is covered, and we need to make sure that people understand that.

We try to achieve that by disintermediating lawyers from it as much as possible and relying on a paralegal staff that we trained. Paralegals tend to speak not in compound sentences and don't use Latin terms and the like, like real human beings can communicate with them. That's a very important. And people that do this have a lot of expertise of talking to people, you know, using the kind of style and forms of communication that expedite dispute resolution.

Following the completion of the internal legal review, normally it takes about a month, provided all information is forthcoming. Again, I say that it's hard to get information, particularly when you've got a medical group, multiple doctor specialists, lots of moving parts. It's hard to get the right information.

We then provide a letter for the member which explains the results of our investigation and, in plain English, tries to explain our conclusion. And obviously if the benefits is resolved in accordance with the member's wish, the matter is over, hopefully.

If in fact the decision has been that the member's position is not upheld in whole or in part, the member is given a demand for arbitration form and advised he or she may proceed with arbitration under the Triple A rules.

The mechanic for that is one that -- we use the commercial arbitration rules of the Triple A, which are prevalent in contracts in variety of industries. But what the member has to do is fill out of the form, say what the dispute is, and put down a dollar amount or estimated dollar amount, what the recovery sought is.

That is then filed with the Triple A, who appoints a case administrator. If the case is under $50,000, the arbitrator is appointed by the Triple A. We have no say in it. It's just the arbitrator that's appointed by the Triple A.

If it's over $50,000, they give you a list of about eight names, and each side gets to strike two or three names for whatever reason. You circle the remaining names in numbered order of priority, and the Triple A then decides who the arbitrator will be.

The arbitrator then fills out a disclosure of conflict of interest form, which the parties get another whack at whether the arbitrator is okay. The arbitrator is then asked what business have you had with us, with the member, what have you. The calendar is set, and the arbitration is held.

The member is not required to utilize an

attorney. Frequently they do not. We don't put an attorney on a person that doesn't have an attorney. And, in fact, our paralegals conduct the majority of the arbitrations that occur in this area.

In '96 we had about 450 requests for arbitration out of 3 million members. And in '96 we arbitrated about 30 matters. Now, our view of it is that if administered by an independent party in a -- where there's unbiased neutral decision maker, coupled with the kind of active intervention -- I don't want to underestimate the value of this act of intervention early on because people tend to get upset, and they get more upset as time goes on that they feel they're not being responded to in a timely, appropriate, respectful fashion. From our perspective, it's an effective mechanism.

The last of the three areas is feedback and results, and I can't overemphasize this. We have an internal process where the legal department advises the appropriate business people inside the company of things where we perceive that the company could improve in terms of handling particular kinds of complaints, in terms of areas of training.

In fact, we try to train people, conduct training seminars for people on the phone, educating of a lot of things like -- you know the risks and responsibilities that are entailed with their job, which is very important, and that they're to contact the member and that the principles, again -- the company's duties to

deal in good faith with its member. Again, this feedback, we have found to be very helpful.

The second component of the feedback group is that that then goes through our public policy committee, and our governing body is advised from time to time of what we're doing. Because the governing body needs to know if -- you know, it's mindful of the types of claims that we're seeing out there currently. And we're directed and do try to use the new procedures to make sure that whatever of a preventive or a prophylactic nature we can put into place is in fact put into place.

DR. ENTHOVEN: Thank you.

MR. LEE: I'd like to ask that people hold questions until we have Mr. Christie's --

DR. ENTHOVEN: Okay.

MR. LEE: I want to make a couple of introduction notes for Mr. Christie. Mr. Christie's dispute was not with Blue Cross, specifically didn't want to have this be an issue of debate, et cetera, rather than provide two windows on the dispute resolution process. What we've asked Harry to do is provide a window of what can happen when the system doesn't work.

And, Harry, take it away.

MR. CHRISTIE: Mr. Chairman and members, I appreciate the opportunity to make this presentation today. What I'd like to do is share with you my family's experience with managed care because I believe it's a very pivotal issue and very instructive and informative as to

what we had to go through as a member of an HMO when our child was stricken with a disease and to let you see what opportunities we had available to us to resolve our differences or grievance with our plan.

I'd like to tell you briefly that when our daughter Carly was diagnosed with Willms' tumor, which is a very rare cancer of the kidney with children, both the medical group and the plan responsible for her care both said a neurological surgeon was suitable for her care, even though, as we later came to learn, the neurologic surgeon had no experience with the disease. They said our request to have an experienced surgeon was not medically necessary. Let me emphasize that.

In the process we frantically attempted to get a referable through our primary physician to the pediatric surgeon who had the experience and who, by the way, was in the plan and practiced at the hospital where the surgery had been scheduled by the HMO surgeon. And there was no time to discuss the issue. The tumor had to come out. This a was very fast growing tumor.

Well, we finally took the medical decision making out of the plan's hands at the 11th hour. We found out about Carly's actual tumor condition on Monday. And as of Thursday, three days later, four days later, we made the decision to have the pediatric surgeon go ahead.

The surgeon had knowledge in dealing with the disease. He had experience in working with it before. Carly has had successful surgery. She's had the recovery.

And the subsequent cure has assured us that we made the right medical decision. I'd like to emphasize that you only get one chance at removing a cancerous tumor correctly to assure the highest probability of survival in children.

What we discovered with our rights with our HMO following that issue became a very frustrating and frightening struggle between us and the HMO. During Carly's stay in intensive care, the HMO called us and advised us that, because we had not sought preapproval, that we would not have the medical coverage provided by the HMO. And this was in spite of the multiple attempts we made through our primary care to get that preapproval.

And 11 months later, while Carly was going through the painful chemotherapy treatments, it was an arbitrator who ruled that the HMO had to reimburse us our medical expenses, which we had to pay in the meantime because the HMO informed in writing both the hospital, the provider, and the doctors that they would not pay. And we recovered not only our medical expenses, our arbitration expenses, but not our attorney fees, which by that time had approached five figures.

I'd like to show you our first slide to tell you what this first looked like. It's hard to see this. The first indicator here is January, 1993. And that is when my daughter was diagnosed with cancer. That was the end of the month of January.

When I got the denial from the HMO, while my

daughter was still in ICU, I thought it was a prudent thing to write the HMO a letter and inform them about the technicality of her care and that she was admitted by the pediatric surgeon as urgent and why we went ahead in the emergency of the case. And at that time I even offered to the plan to cover the cost of the pediatric surgeon. As was mentioned earlier, it's the plan's responsibility to reply within 30 days. So in 30 days I got a response to the plan saying that our request for reconsideration had been denied, that we had not -- had not gotten preapproval.

This is a very important juncture I think we all should know about because the minute I submitted that letter to the plan, it initiated something I was completely unaware of, and that's called a "grievance process." Once you submit a letter to the plan, you are no longer in a medical situation. You enter into a contractual situation with the plan.

So the issue has now moved from the medical group into the plan where it's considered a contractual issue and no longer a medical issue. And that's a very important distinction because had I not submitted a letter and had been able to go back and possibly discuss it with the medical group, we might have resolved this. But that's a critical juncture.

Following that point in January, I filed a second letter in February to the plan, asking for reconsideration again. And according to my plan's

grievance process, you can submit up to three letters. You can see a space there at the end of the third letter. I think the third request was some time in June that I made. And when that request was denied again, I was told that I could elect to try arbitration to resolve my complaint.

The thing I didn't know and I got informed quickly of was if a member does not initiate a request for arbitration within 60 days, the issue is a fait accompli. The issue is resolved in favor of whatever decision the plan has made. So the enrollee has to be on top of themselves to make sure they submit the requests at the appropriate time.

The fact you have a child who's sick who's lost 30 pounds in weight and all of their hair, coupled with the fact you're going to chemotherapy every week and the fact you've been told you have medical expenses, you begin to get an idea of how friendly the grievance process is.

There was no one to turn to in that time frame. It was really a very lonesome road to travel. And it wasn't until I completed the third level of letter writing that I finally enlisted the services of an attorney to file the arbitration -- request for arbitration.

And I must say that in our specific case, we had to take depositions. Not only did I have to pay attorney fees because under an ERISA plan, which it was

categorized as, you're not entitled to recover attorney costs. So from the day I hired attorney to file arbitration until the end of the arbitration, which is in December of 1993, all of those costs were my costs to bear. I won't begin to tell you how many hours of time it took to go through this process for me and my family.

I will tell you that the arbitration finally commenced in October of 1993, and this is supposed to be a green line. That green line is to indicate that there was a delay of approximately three months to get the arbitration underway. That involved deciding or having names of potential arbitrators submitted. And then finally the arbitrator was selected and his calendar was free to hear the case.

So we had a three-month delay in the arbitration proceeding, at which time the beginning of October of 1993, we went for a full-day there. We reinitiated the arbitration process in November of '93. 30 days later in December of '93, the arbitrator awarded us our medical expenses. I'd like to emphasize the terminology that we were awarded our expenses as though we received some sort of a prize, which in fact was a reimbursement for the expenses we had to undertake in the meantime.

I would like to briefly say that in my experience, the dispute resolution process has serious shortcomings. From our standpoint there was no sense of compassion, fair play, or common sense on the part of the

HMO. Specifically, in spite of our repeated attempts to get the preapproval, none of that was ever mentioned in the letters that came back from the HMO to us. The HMO kept saying there was no apparent medical necessary reason to use physicians outside of the group. You'll see, as I continue with this discussion, that this proved to be false.

The third thing I think the task force should concentrate on -- HMO policies resolve all complaints within 30 days. And that is a stated policy item in the evidence of coverage handbook. It took us, if you saw by the previous slide, 330 days to complete the process.

Because of the multiple levels of review, you may not get the process completed to your satisfaction in the first review. But then you have other levels of review to go through. So a 30-day period for reviewing your claim, I think, is a misstatement of the issue.

Next slide please.

Here is what I think we face as HMO enrollees. I feel clearly -- we struggled with denials when we're least prepared to deal with them when we're sick. Contractual language provides various inappropriate medical care. That is, your primary care physician will authorize all specialty services and what that really means -- the HMO has the final say over all medically necessary determinations. The review is completely one-sided by the HMO. And there are potentially harmful consequences when treatment decisions are delayed by HMO

denials. And what I came to learn by this was do we risk or health and possibly our lives when we don't insist in a proper medical treatment, whether or not that treatment falls within the HMO guidelines.

Next slide, please.

Now I'd like you to see this slide in a little more graphic detail on the other. The red section of the slide is the phase one we talked about earlier. Following the arbitration in December of '94 -- sorry, December of '93, I'd like the task force to know that when an arbitration is completed, the substance of that arbitration is completely erased off the record. There is no case law developed because of it, no subsequent or follow-on case can use any of that material for the basis of future arbitrations that may come along. And I think that is a real shortcoming in arbitration.

I filed a formal complaint with the Department of Corporations within January of '94, and the department finally announced a fine to the HMO in November, '94. Subsequently, within that month the HMO requested -- pleaded a defense plea to the department. And almost a year later, the state of California initiated an administrative hearing on behalf of the complaint.

Now, subsequently after that, the HMO tried filing a summary judgment motion in Los Angeles Superior Court saying they were being denied the due process. And it took effectively two years -- almost three years -- 32 months for the state of California to enforce the

regulations of the Knox-Keene Act and to enforce that fine to be paid by the HMO. But the state paid a dear price in enforcing the regulations.

Next slide.

These are the findings of fact by the administrative law attorney in the case. The HMO failed to provide a ready referral, failed to make specialist services readily available, failed to demonstrate that the medical decisions were unhindered by fiscal and administrative management, attempted to mislead the state regulator in its representations and responses, most importantly refused to acknowledge the legal responsibility to enrollees for medical decisions made.

Last slide, please.

My conclusion that I'd like to bring to your attention is when HMO review processes are not opened to outside medical scrutiny, those processes can have defective systems with potentially harmful consequences to enrollees.

MR. LEE: Thank you very much. If I could continue to facilitate this topic of discussion, to have a few minutes of questions for both of the speakers. Again, I'd rather not have a discussion of cross questions about comparing issues. They're separate presentations.

And with that, I'll facilitate any comments.

DR. ENTHOVEN: Mark.

MR. HIEPLER: Does Blue Cross have statistics on the length of time from the -- 450 requests how many of

these are completed within the calendar year of '96 and then the costs to the complainant or the enrollee to go through arbitration?

MR. CHRISTIE: The former part of it, we're in the process compiling. The latter, I don't think we do.

MR. LEE: One of the things you noted was that in '96 there were 450 requests for arbitration but only 30 matters actually arbitrated. Is the balance of the 420, were most of those resolved informally either in the process of going through the legal department's review or resolved in other ways that people didn't take it all the way through to arbitration?

MR. CHRISTIE: That's right.

MR. HIEPLER: The 30 could have been started in '94, '95? They aren't part of that 450?

MR. GUYSER: No, they aren't. But the purpose -- well, what it shows that if you have -- effectively deal with the request, you know, hopefully, you can resolve it to the parties' mutual satisfaction without the need to consume resources. And as Mr. Christie said, it's telling on both parties to go through that process.

MR. HIEPLER: One suggestion is that it's a abominable that Blue Cross is trying to put the statistics together. But having been in quite a few of those processes, I think it will be rather telling to find out in Harry's -- seemed to be rather reasonable that if the

costs that he had to incur -- when you get into Triple A arbitration, most people don't understand the difference in that in a Superior Court, you're not paying for the judge's time. You've already paid for it through the taxes.

When you get into an arbitration standpoint, the actual person who is taking on a large HMO or a small HMO is paying for one arbitrator. And many times, as in the Kaiser context, you're paying for one and a half. And those people go much more, usually much higher price than the attorneys do, and usually to two to two-fifty.

We've had arbitrations for people that have cost them, not with any attorneys fee included, forty, fifty thousand and have taken two, three years. And most patients can't ever bear that. Many law firms can't ever advance all of those costs.

So that's an interesting element that you need to be made aware of when comparing arbitration as the most cost effective fast way to resolve disputes. I'm always interested in the status on that. Thank you.

DR. GILBERT: Two-part question here. Who made the original decision to have the non-neurologic surgeon? And, two, you made the comment about when it moved to the HMO, it became a contractual issue. In many plans the grievances -- the grievance like yours would be immediately handled within the HMO as a medical issue on an urgent basis, and the contractual issue then became a part of that.

But did that get separated because it was a decision of the neurologic surgeon who didn't have any ability to do anything like that about that medical issue and then later it became the whole issue of preapproval and finances?

MR. CHRISTIE: I'm not sure I can give you a full answer to your entire question. Number one is that the initial denial was made by the medical group. And that denial was supported by the HMO. My initial call came from the medical group, and it got supported by the HMO.

Now, my point to you about the fact that when I submitted the letter put it into the grievance process is an important one because once you file that letter, it now becomes a registered complaint or registered grievance. And in my experience -- and I can only speak for my specific experience -- that now takes it out of the medical realm and puts it into a contractual one.

When I sat across the arbitration table with the plan on the other side, I can't tell you how many times that evidence of coverage handbook was put in front of me, and told me what my rights and responsibilities were. And I wish I had that education when I first signed up with the plan several months prior to that.

DR. GILBERT: I don't think that's universal. I mean the registering of a grievance sets in motion a specified process as mentioned in terms of DOC and DHS regulations. But the ability to deal with the medical

issue essentially in a way -- there was a denial of the medical director level of the HMO. It almost got separated. In many plans, both are handled simultaneously.

MR. LEE: Part of the intent of the presentation was not to present anything that's universal, but there are broad anecdotes for different experiences people have.

Since we're running overtime, I'd like to move to the next part of our working group's portion.

And thank you both very much for coming and presenting today.

Our working group, Barbara Decker and myself, staffed by Sara Singer, providing great able assistance is going to try to do two things. One, give a picture of the task force on what is and what's working and what might not be and make recommendations.

What we want to do today is tell you briefly about the process. I will outline our initial take on what we consider the initial elements that is the measuring rod against which we think any process should be measured. And Barbara will run through the preliminary recommendations that we're considering bringing here for more discussion.

In terms of our process, we are soliciting comment on dispute resolution process from both task force members but also more broadly from consumer advocates, health plans, purchasers, medical groups. The range of

staples that we think need to be involved in the dialogue and were involved in. Part of what we're soliciting from them is their comment on a number of the questions we're wrestling with but also from the health plans, both HMO's and PPO's, and description of the process they run from.

You heard one window of it here from Blue Cross. I'd like to consider a broader picture of what is the range of how different health plans cover grievances internally. Some of the essential elements we would like the task force to consider and, hopefully, in the future adopt are -- really should frame what are the right recommendations we should make and then frame the evaluation of different dispute resolution processes. I have to walk through those quickly.

First, I noted before, which is to encourage resolution at the lowest possible level. I'm still confused about these rules about when to put something in writing, what happens to it, et cetera. There's a couple essential elements that relate to consumers and their need to understand the rights, responsibilities, and also to understand the process of their plan and how to navigate that process.

The fourth related to consumers is some consumers are absolutely going to need assistance. So an element of the use in the process is how do consumers get help navigating the process, whether internal in the plan or external?

There's a number of elements relating to the

formal processes when people have identified they have a dispute that we think are essential. The processes have to be fair. They have to be perceived as fair. And some of the elements that relate to that -- well, not -- it's important that the dispute resolution process should, again, be facially valid in its processes.

The formal process need to communicate the findings to the consumer, along with the basis for those findings. The process needs to be predictable and need to treat like consumers with similar problems alike. They need to reach decisions based on opined facts to the case opined explicit standards. The process needs to be efficient it needs to be efficient both from the plan's prospective but also from consumer's and patient's perspective and needs to recognize severity of the issues faced by consumers. Finally, there needs to be appropriate finality. The decision process can't drag on.

The last element for the process -- I noted it earlier, but I think it's important -- that not only is the process needed to work for the patient, the individual and consumer problem, it needs to work for the system. It needs to provide information to inform the system that identifies potential set of problems and has mechanisms in place to fix and improve those problems.

So those are some of the essential elements that we look forward to using for measuring stick against which to measure our recommendations and which will

measure so that what's currently in place today.

And with that, I'll turn it over to Barbara.

MS. DECKER: Peter and I have been talking, with Sara's help and input from several other people outside the task force, about where we potentially might be offering recommendations. And we are thinking in a very broad context that we may come up with proposals that we would present to the task force which would apply for voluntary action by health plans, perhaps requirements and suggestions for purchasers, some thinking around what outside entities might recommend, such as health care professional organizations, accreditation bodies, and then modification or suggestions for new regulations and perhaps legislative actions. So we're not trying to think of one way. We're trying to be very broad and think of a variety of approaches.

Again, these are just preliminary. We're putting them out here because we're seeking your comments, your ideas, your suggestions, and where else we should be seeking input.

The first item concerns that all enrollees in managed care plans, no matter what type of plan -- so we're talking about HMO's, preferred provider organizations, point of service plans, self-funded plans regardless of type, should have the same procedural rights and protections regardless of the plan type or who's paying for it. So we're thinking of consistency for ease of understanding on the part of all parties. Of course,

we immediately think about how we're going to do that, but we're not letting that bother us yet.

The next suggestion is to be educated, empowered consumers will need full information on their rights and how to exercise them, and information must include clear communication of a, for lack of better term, a Bill of Rights and responsibilities. And I stress there's both sides there, a right and a responsibility upon enrollment, which would include clearly avenues of pursuing issues and complaints.

And then also this information, I believe, needs to be presented again whenever a decision or information or a potential misunderstanding may be taking place. So at the time the consumer actually needs the information, present it again.

Our employees never remember how to use the plan until they're trying to use it. So it's important to get information out there at the time it's needed. Our big question around that is how to figure out when that time is because it might just be a physician saying "I think you should have X," and there might be three other alternatives. And I cringe at the idea of physicians having to say "Okay. I think you should have X, and here's your disclosure form about the other treatments that might be possible."

That is not at all exciting to me, and I'm sure it would not be welcomed by other members of the task force. But, again, think about the range of times when

information is reported and how do we identify those and trigger information provision.

Our goal is to educate and empower consumers to be their own advocate. We want the patient to be the one or the family to really understand what they want and to be part of the decision making. But some patients and consumers, we think, will not be able to exercise their own rights individually. They will need assistance in some way, shape, or form.

We think physicians and other health care providers can serve part of that role. But the plans must have adequate internal systems to provide assistance and that some assistance comes from other sources such as employers, insurance brokers, other parties of interests that might have helped secure the coverage.

But also some consumers may need to have an independent external resource to go to. And we're concerned about where the funding for that would come from and a fair way that it would be applied since we're trying to look across all types of plans, some of which might be self-funded and not have a premium that could be looked at for a charge.

We're also concerned at the consumer in that a particular recommendation, recognize that they don't go immediately to the external source that they need to pursue the assistance of help within their available range first. In other words, talk to their provider, talk to the medical group, et cetera, not automatically go

outside. And that's the end of that one.

Our next proposal is regardless of plan type, plan's internal processes should have common standards. And these might include -- and, again, these are just thinking items potentially -- a turnaround time for handling complaints with that adjusted for acuity, severity of the problem. Again, five days versus 30 days, 24 hours, et cetera. Its based on what the medical situation.

There also needs to be a time frame that the patient and consumer must understand they have to present their claim within. They can't be, to exaggerate, four years later that you come back and say "I don't agree with the physical therapy that was provided for me there." So there has to be an end.

There needs to be demonstrated support provided to individuals seeking to appeal. There has to be precedents established and shared. Here's where the appeal issue and the arbitration that Terry was talking about is of concern to us. We're not building information that helps consumers and other entities understand how the system works and build on that knowledge and help people make informed decisions about which plan they want.

Some way, we need to share the basis for decisions while maintaining appropriate patient confidentiality. One idea has been that we have a plan appointing an internal quality auditor that is appropriately situated and buffered in the organization

that would just report to the plan board and also to perhaps an external oversight body.

Another concept might be to have a periodic perhaps annual report to the state plus each plan's board of directors and to the public of the complaint data by standard characteristics and how they were resolved, which would describe the process by which the complaints were handled and analysis of those complaints. Finally, how the plan used that information to improve their own processes.

So, again, we're concerned about what's a complaint and how to make sure that we are setting up process that's encourage immediate resolution at lowest level and how to ensure that things are comparable and fair when they're reported and how to structure this in an efficient manner.

We think at some point in the appeal process there should be an independent third-party review available for all enrollees. This is beyond those that are currently available for Medi-Cal and Medicare. And we just don't know how that should be set up. So we're seeking ideas and your comments on this. Where should it reside? What kind of agency or entity? What kind of structure is necessary to make sure the reviewers are appropriately insulated from pressures and possibly conflict of interest? What kind of people should be involved in that? What kind of qualifications do we need? Medical? Professionals? Do we need people that

represent consumer views? Do we need plan experts? If someone chooses to go to this outside process, how does that impact further legal remedies?

Another idea we're considering is that the state should establish some kind of arbitration standards for those plans who choose to use either binding or non-binding arbitration. Those standards might include how the neutrals are selected, standards for when costs of the arbitration should be borne by the appellant, and standards when prevailing parties should be borne the costs.

And another idea, we think we should have some emphasis here on health plans, providers, foundations, consumers, et cetera, to start and be encouraged to assess the efficacy of a full range of dispute resolution mechanisms. In other words, let's try and encourage looking outside the processes that have been in place historically.

We might find some kind of new work that could go forward, looking at stated public policy goals, looking at binding and non-binding arbitration, mediation, neutral fact-finding, other types of approaches. And this would require or we recommend strongly that this evaluative process would be disseminated to the public and hopefully used to improve processes going forward.

Those are our thinking. I want to reemphasize none of this is for sure. We've just been talking back and forth and having a great time trying to

be a little bit out of our normal boxes and share concepts and ideas. And we welcome your input and suggestions on where we should go for additional information.

DR. ENTHOVEN: Thank you very much. Will you be circulating an outline or draft that people can work on and write back to you?

MS. BECKER: We're concerned about those rules.

MR. LEE: What we have circulated to the task force is 15 questions that really -- implicit is the questions is potential recommendations and that we have distributed as task force members and as public document So that's our document which is public and out there in the world that we encourage responses on.

DR. ENTHOVEN: Thank you.

Rod Armstead.

MR. ARMSTEAD: This is excellent. I do think that all the areas that we touched on and -- this is just really a comment. All the areas we've touched on, the area around the consumer complaints and grievances and appeals and how we deal with really represents probably the most dramatic, probably the quickest thing that we can deliver as a result of what comes out of this task force. And I think that that's important.

I would say that the challenges that we have are following that there are a number of things that we're all trying to respond to. We are trying to respond to needs and requirements from the health care financial

administration, and Medicare, State Department of Health services has their piece. And I think that responsibly the Department of Corporations have their piece. And I think that one of the things we need to try to see at one end grid together is to begin to look to see where that is.

There are some things that are going on that we should not reinvent the wheel in the context of throwing the baby out with the bath water. There's things that the DOC is moving on. And I think that from my perspective in being someone who isn't an executive but who still sees patients in an attempt to stay grounded to these realities. In fact whatever we do, we should try and find and resolve at patient-doctor level, patient-provider levels, really, is what it is.

If had has to escalate to be something, something is wrong. If I'm sitting there, having to make a call about this or that, there's really issue -- because for me it's never an issue of coverage. I really kind of get into -- when I look at it, I always look at it if it's medically necessary. That's the end of the discussion, and we need to deal with it if it comes up.

Whatever it is you do, we try to come up with recommendations that are exact. The more you try to deal with stuff externally -- and you have to understand that that expands confusion. As much as we don't want it to be, that expands time. So we now expand the amount of time it takes to resolve an issue in a timely fashion.

It also brings in other variables that it increases the whole issue of the inability to control. And so I think tighter to the provider and patient, tighter to really pressing down on how the process is being managed within the managed care organization.

And I think the truth of it all is that the context of what's going on is that, really, you can talk badly or -- whatever the opinions about managed care. What we're seeing is in evidence of escalation of probably what has been a problem within how health care is delivered within our system.

So I think this will help to postulate ideas and changes and will help in general. So I think this is the one we hit a home run with.

DR. ENTHOVEN: Thank you, Dr. Armstead.

Dr. Spurlock?

MR. SPURLOCK: I'd like to make a couple comments about maybe the title and consider adding the word "early." I think it's a win-win for everybody and piggy backs what Brad was talking about. The earlier we review this in the process, the better everybody wins.

Second of all, on that idea I'd like to promote investigation and some explicit component of this and how do we improve that process. Most of the recommendations you made I agree with completely. I'm there at the higher level of the patient-physician. And if we really want to improve this process, how do we do this? My suspicion -- understanding some of the

literature on some of the process, it's about communication between patients and physicians. And how do we promote that?

And I think it gives the task force the opportunity to use it -- task force to wholly focus to encourage improvement of communication between the physician and patient as a way for early dispute resolution.

When you look at the malpractice literature, most of the issues relate to communication, not to medical care. However we can incorporate that into the paper, and however we can incorporate that into the recommendation, I think that's where we leverage our effectiveness.

DR. ENTHOVEN: Thank you. I hope you can look carefully at barriers to early compromise. One of the things I find so striking about Harry's case is that he offered them a very good deal early on. I'm just wondering is there some legal or administrative -- were they afraid of setting a precedent? What got in the way? Was it just a bad judgment by somebody?

MR. CHRISTIE: I don't know or will ever know the answer to that. But I frankly think the contractual language was put in my face, as you would say, and I was told clearly that because I didn't get preapproval, I was not entitled to coverage. And that was the resounding theme that came out of these three levels of review. And that's why I said there was no sense of compassion or fair play.

So the best I can tell you is the HMO used the contractual language as a way to deny us the opportunity to resolve the issue.

DR. ENTHOVEN: Not only no sense of compassion or fair play but just -- I don't want you use the word stupid -- but it's just dumb not to accept -- to say, you know, can we negotiate this.

Is there something in the law or the process that --

MR. LEE: No dumb actions?

DR. ENTHOVEN: -- that prevents people from --

MR. LEE: Our recommendation on that is specifically that there are a number of ways to resolve disputes that are -- to a different extent and information about how effective those are need to be considered and need to be shared with part of the discussion and whether it's neutral fact-finding, mediation efforts. Those are important vehicles.

MS. BECKER: Let me mention that the basic premise -- and I don't know anything about this case. So I can't speak to that -- but in the appeal processes that I've been involved with in ERISA plans, you have to be ready to do the same things for any other patient in a like circumstance. You don't cut unique deals for certain situations just because it's expeditious. You should be ready to pay for it if it's appropriate. So you're not negotiating to try to cut your costs and meet the

patient's needs. You're saying is it appropriate within the plan.

MR. LEE: A couple of the comments made -- I agree strongly that whatever we can do to encourage issues not ever coming to dispute but address at the physician level would be a great benefit. We'll consider how to do that. I think that it is absolutely the case of the law comes down to doctor-patient communication.

One of our perspectives is that the more there is a structure that people trust, that if there was a problem, it gets resolved fairly, the more they don't feel they would use it, necessarily. Right now there's a lot of question about that.

The other about the compromise deal cutting issue is that one of our concerns is that we think it's not right just to have the squeeky wheel, so to speak, get better care than a plan. And that's our concern with precedent saying -- and having the quality and improvement feedback which is that care that is covered care should be covered for everyone, whether or not they're articulate or, as the case with Harry Christie, could afford to get counsel and pursue something where other people couldn't.

DR. ENTHOVEN: Helen Rodriguez-Trias.

MS. RODRIGUEZ-TRIAS: I guess I was groping for a connection between what the previous group presented and this.

And thank you, Harry, for sharing your story. I think that -- could some of this be preempted by

having inserting in the decision-making process some of these quality standards we talked about? I mean it was obvious in the case of Carly that you would have to have someone who had had experience with that particular tumor to have a successful outcome and that that should have been looked at very much at the beginning rather than letting it become a grievance to begin with.

DR. ENTHOVEN: Okay. Thank you.

Mark Hiepler.

MR. HIEPLER: One suggestion. Just because we've been involved in over 250 managed care disputes, one thing that amazes us is that in every case we try to get the patient to resolve it themselves somehow, some way.

When we look back at the ones that sometimes have been notable and have large verdicts, at some point in the grievance process, they haven't had high enough level decision makers there to make a decision. And you've had someone who -- you know, they would send someone out just to staff this grievance process with the knowledge that this is probably not going to be successful. And then it just got replicated from that point on, and it continued following that the greater the time went with some life threatening illnesses to the greater the dilemma. And all of that became amplified with time.

So I think the higher the level the staff person becomes involved -- plus the financial incentives come into play. If you have a medical group decision and

that medical group wants to reserve its decision to perhaps do what is the right thing, they know the HMO is going to impose on them the cost of that outside treatment. So they want to usually force that in a network model HMO up to the HMO executive level because if that person makes the decision, then it will be coming out of their pocket.

So underlying is the different financial incentives for each level and whether or not you have someone with authority during that process to make the decision and won't actually hurt that person financially.

MR. ARMSTEAD: Taking Harry's case, I'm not saying in the context of our plan. It wouldn't have been an adverse financial relationship to the group because once they get hit and -- 100 percent of that would be picked up by us. This is a problem that someone just made. When I look at it, it's like there is no financial disincentive for someone to make the right decision.

All I'm saying is that there has to be a provision to protect the medical group or the doc from this type of senario based on you make the right decision. And that's the way it is.

DR. ENTHOVEN: J. D. Northway, and then we'll stop.

MR. NORTHWAY: Unfortunately, the example Harry used is not all that uncommon. There are a horrible cases where one decides they're not going to refer to pediatric subspecialists because they're not exactly in

the group. They may in fact cause the group some extra financial load. So they don't do it, and we have to argue on a regular basis to make sure that the vulnerable population does not get hung up and get inadequate care or possibly potentially inadequate care.

These are not uncommon. They happen in the pediatric realm almost all the time. Exactly how to deal with them through some kind of legislative issue or other issue is difficult. Because it should be common sense. The common sense often times get altered a little bit when it comes to financial reality. But this is not an uncommon problem.

DR. ENTHOVEN: Thank you very much.

We're going to break for lunch.

(Whereupon a lunch break was taken.)

DR. ENTHOVEN: Will the task force please come back to order.

We'll begin the next part of our managed care oversight meeting. Clark Kerr is going to facilitate this beginning with a presentation by Dr. David Hopkins. He's the director of health information improvement for the Pacific Business Group on Health.

I'd like to say that when we think of who are the important oversight agencies for managed care of California, that we've heard from DOC and CALPERS. The other really big important agencies do this through includes the Pacific Business Group on Health acting on behalf of the major purchasers in California.

DR. HOPKINS: This was supposed to be an overhead presentation. But looking at where the overhead projector is, I think it might be better if we tried it a different way. So please find at your seat the handout with the title with my name on it. I understand I have about 20 minutes.

DR. ENTHOVEN: Right.

DR. HOPKINS: "Private Sector Efforts in Managed Care." I'm also responsible for this little brochure.

I want to thank you very much for giving me this opportunity to share with you some of our initiatives and activities and so forth in the private sector of initiatives in managed care.

What I'm going to do in the next few minutes is tell you briefly who is, what is the Pacific Business Group on Health. Then I'll tell you about what kinds of things we do to advance our quality agenda. Really, there are two parts of that part. One is quality measurement. The other is introducing incentives for improvement.

Next I want to touch on data and critical importance of data and the data that we don't have and what we need to be doing so we can get it. I'll finish with specific recommendations.

The second page of the handout shows you the companies that belong to PBGH. These are big employers with at least 2,000 employees in California, including public, as well as private employers. In fact, CALPERS is

one of our original members.

The mission of the PBGH in a nutshell is to improve quality while moderating costs and managed care. We almost exclusively emphasize managed care in all our activities because three quarters of all the employees of these companies belong to the HMO's.

On the next page is a funny looking equation. It says "value equals" with stuff on the enumerator and costs on the denominator of the that equation. That's essentially our value equation. We're trying to find ways to purchase health care for our member, our employees, according to best value. And the way you get value is to compare quality with costs so everything you see in the top there is an indication of quality, outcomes, change in health status, and satisfaction.

I would ask you to think for a moment of the items on the enumerator that fraction how many pieces of information do you think we have today that relate to that item? I would argue we have very little on outcomes and practically no scientific evidence on change of health status. We do have data on satisfaction.

Next is our definition of quality care. We have a quality committee of PBGH that's been active for many years. And recently they came back to their basic core mission. And we're looking at what kinds of quality initiative we would engage in from here forward. To guide them in that, they revisited with "What is quality?"

So we thought we'd share this with you. In

our view, quality care has three critical ingredients to it. One is appropriate to the patient's condition. The second is it maximizes likelihood of desired health outcomes. Third is the way it's delivered; namely, timely and patient-satisfying.

The next page is a grid which sums up the way we look at quality and the way that we're moving in our agenda to get from where we started, which was the ability to collect crude measures at the health plan level and drill down not only to get from structure to process to outcome measures for health plans but also to drill down to a lower level system; namely, provider.

We start with accreditation as being fundamental for all levels. Today there may not be a simple accrediting body for physician groups. There are several that are either in that game or soon will be or will look to them to give us some basic standards that must be met. And there are process measures that come to NCQA through HEDIS and others. Finally, we have outcomes like the survey under health plan -- NCQA survey is the patient satisfaction survey. And I will talk to you about the physician value check survey, which is the one in the lower right-hand corner, which is looking at physician performance.

What happens to the information that we compile from these sources as quality projects is that it gets assembled in ways that are useful to consumers not only for the members of our companies but actually the

public at large. So this little brochure that you see here -- you'll see that there are various kinds of report cards in there. There's a HEDIS report card that was actually provided by CCHRI. And there are satisfaction report cards and accreditation products. This will be expanded as we get more better measures in the future. That's one thing that we do is get that information out It's actually out on the web site as well.

I want to tell you briefly about one of the projectors that was on that list. This is the provider ratings of California HMO's. This is physician groups being asked to evaluate their relationships with their HMO's. And if we look at the -- there's a title page if you look at next page entitled "Enrollee Education." You will see interesting results. I just selected one of the dimensions that was covered in the survey to show you what kind of results we would get, and I thought this was of particular interest to you. How good a job does the HMO do in explaining various things to its enrollees? The full process, how to select providers, what benefits are covered, and their grievance and appeals process.

You can see the kinds of results that we're coming up with here there. There's obvious room for improvement, which is why we do this. Please bear in mind that physicians are generally arch critics, particularly of their HMO's. You may look at this and say "Wow. It's terrible," but I'm not sure if one compared it to other surveys, that we're doing so badly. But we can do

better. We must do better.

And we will be pressing the HMO's. We actually put this on the table when we have our contract negotiations with them. And we explain to them they needed to improve these as well as other things.

The next page are some bullet points relating to what we call "Physician Value Check." This is a survey of patients on the -- their satisfaction and their view of the care that's provided by their physician group. It covers all of the things that are shown here. Satisfaction with care, health and functional status, whether or not they received the services that they should have.

Particularly interesting is singling out two chronic conditions that are fairly prevalent in the population to see how well it was handled relative to the guidelines. And we included a non-managed care group in our survey set for comparison. I don't have the results to present to you today because they're being reviewed by the research group. They'll be available in mid-September.

That's all about what we call "county quality and measuring quality and putting it out on the table so that the health plans can see it but so can consumers.

The other thing we do is try to make quality count. How do we do that? That gets to our negotiating function. Our function as a negotiator on behalf of not all 33 members but nearly 20 with the plans in a single

body.

And we built into our contract specific performance measures. They may be HEDIS rates. They may be customer service criteria and various things of that sort. Actually, more recently we have built in report performance having to do with information systems. And I'll make clear why we think that's so important. This is where we have our teeth. And actually 2 percent of the premium is put at risk for these measures.

The other way that we try to make quality count, as I've indicate, is to get this information out as widely distributed to the public as we can through web site, newsletters, brochures, et cetera.

I'm going to switch to the other topic, which is data. You may recall Dr. Millstein made a point about -- I don't know if he put it quite this way, but he may have. Essentially, the system was oftentimes flying blind in relation to what is being done for patients not because anybody attempts it that way but because we don't have -- and physicians don't have the data and the information at the time that they need it.

The first is CCHRI. In case you're tired of these acronyms. It's the California Cooperative Health Care Reporting Initiative. It's a very large collaborative statewide, includes purchasers, plans, and providers. I think the plans cover about 95 percent of the commercial HMO population in the state, and it's basically dedicated to quality reporting in California.

Now, what it does is gather data -- it's primarily focused on gathering data for HEDIS rates. And flip the page. You'll see a bar graph which shows the rates which were reported last year. So about a year ago, based on '95 data, that tells you something about time lengths that are involved in getting and collecting data to do this sort of thing.

But on a statewide basis, you can look at this preventive care rates compared to the U.S. Health Care Preventive Care Task Force year 2000 goals and see that if all but one case we're not there yet -- although you could also see that this is increasing over time and that in one case, mammography screening, the performance in California had already exceeded the goal last year for '95. So these are the summary results for that.

The graph on the next page is meant to make a following point. What you're looking at is three years of studies by HHCRI collecting the HEDIS data '94, '95, '96. And in the foreground -- in order to collect this data, we go to health plan computer systems, and we try to find the results there. If e don't find them there, we go to medical charts to find them.

So this is truly a measure of how well equipped the health plan information systems are to answer basic questions such as how good a job did you do on childhood immunization or prenatal care or mammography screening. And what it shows is that for the two years prior to this one, we -- it's hard to read, but there were

about 45,000 cases total. And of those, fewer than 10,000 could be found in the computer data base. And we had to run around finding 20,000 plus charts.

This year the whole thing exploded. There were more measures -- doubled the whole effort and instead of 40,000 charts, nearly 80,000 charts. This may help explain why in the vernacular PPGH we say every quality project becomes a data project. This also is a very costly activity for all of us.

So why is this? Well, I think we all know the answer. We've got systems that have been around a long time and were created for a different purpose throughout the health care system. And if you look at the time trend of investment and information systems in the health care industry, you find it is way, way under what it is in every other service industry.

Until recently the annual rate of investment was running around 1 percent. And in almost any other service industry you could think of, it was more like five or ten banking -- was in the double digits. What's happening in banking is that we have automated teller machines.

So what's the fix? In a very summary way, I think the three bullets on the next page, which is labeled "Data Infrastructure Requirements" sums it up. We won't solve the problem until we have truly computer-based patient records, something that will capture data at the point of care and capture data that are needed both for

the care of the patient and for ultimately the measurement of care that was delivered.

If the information is captured but it only sits at the local computer, it's not of great use because it needs to be moved around. Patients move. Health plans need to evaluate all care provided to the members, et cetera. To do that, you need electronic data interchange.

The third bullet talks to how the system can be optimized the care of patients by making sure that physicians and other providers have available to them what Dr. Spurlock was describing to me over lunch, was just in time information.

So how are we going to get there? That's not something that will happen overnight. PBGH has spent a lot of time talking with the plans and the providers and actually now has a process underway with everybody at the table. It's an organized approach. It's a collaborative process involving all the parties. And what we're trying to do is build this infrastructure in stages so it starts with. Let's agree on universal identifiers for patients and providers.

Actually, the federal government is now taking the lead in that, and we sure hope they deliver it soon. Once that's occurred, we feed to set up the pass enrollment and eligibility data and up and down the line through electronic data interchange.

Stage 2 is to get working on the more clinical side of things. Pharmacy and lab records need to

be standardized as to encounter records, and we need electronic data interchange. When you get through that and have the ability to combine what already are in the industry standardized encounter records -- the HCFA 1500 or the UB92 forms that were designed by HICFA, combined with or integrated with pharmacy and lab records, you will have something which -- the chairman of our data committee happens to be a physician -- has pretty good electronic medical records. So there will be a lot of things that aren't there. And that's why we move on to stage 3.

I think the main pitch I want to make on this is that truly the only way to make quality count -- and I would add to form public policy -- would really press forward on this information systems agenda. I know that's the point that Dr. Millstein was making when he was here. So one thing that I specifically wanted to say today is we would really welcome the state getting behind this initiative, joining us -- the Department of Health Services already has -- and let's see if we can move this forward together.

Let me conclude with a few recommendations. First, if you follow the logic of what I've presented and see that there's nothing necessarily private about it, it applies to all of us. We would like to see your support -- you, the proxy for the state of California -- support private sector initiatives. Do not create redundancies or stifle innovation.

And example of redundancies that -- that

might be? How about a public sector version of CCHRI? Let's not -- let's bring the public sector together with the private and do that. How about the state of California deciding that it's going to create its own set of patient identifiers that doesn't fit with the commercial sector? Well, Medi-Cal patients come in and out and sometimes end of commercially insured and we will not be able to track information easily for them in that kind of situation.

I think a lot of your discussion was on regulation. And to me one of the redundancies that exists today is that when -- my observation that when a regulatory body like DOC looks at health plans, they often feel the need to collect the same set of information that the health plans already collected for accreditation.

Now, accreditation is not necessarily the highest level of standard that one would want to set for an organization in health care, but at least as a floor -- and I would hope the regulatory bodies could accept the information that's already gather and then whatever else is needed in addition to that would be certainly appropriate.

A second recommendation is to encourage public-private partnerships. Now, a very good example of this -- there's a project on the list that I showed you in that grid, which is the CABG mortality outcomes reporting project -- where PBGH got together with Department of Health Services and on a strictly voluntary basis were

working with the hospitals throughout California, collecting the data.

What's interesting is that if you put it in the context of legislation which is an AB 524, which is mandated outcome studies, the state didn't have the authority to force the hospitals to gather data that are not written into a different law which mandates exactly what data elements can be collected by the hospitals. That's another subrecommendation of mine is can we please get away from legislation that is down to the level of data elements that may or may not be collected.

But, at any rate, the private PBGH and the public hospital, when they get together, creates this project. We're getting great cooperation with the hospitals. And as a result of that, the public will get information on a very important measure of outcomes.

And my last point is use your purchasing clout in the state of California to advance these data and quality initiatives -- ours, yours, and everybody elses.

MR. KERR: Thank you very much. Any questions from the task force?

DR. ENTHOVEN: A very important part of the power of the purchaser is that the supplier does not have 5th amendment rights. That is, PBGH doesn't have -- the suppliers to PBGH don't have the constitutional right to be serving PBGH employees. So PBGH, as purchasers, can say "This is the information we need, that we are going to do business with people that do it."

If you try to use the legislative group, then you get caught up with the constitutional rights of the providers, and you can't put them out of business because --

MR. KERR: That's right.

MS. RODRIGUEZ-TRIAS: Thanks very much for your presentation. I really enjoy that type of work. I wonder how much more are you looking into outcomes that are indeed outcomes? For reasons -- I mean we look a great deal at some of the process measurements such as your pap smears. But do we look at actual prevention of cervical cancer as the outcome, as an example?

DR. HOPKINS: If you'll permit me, I'll take a slightly different example, which is mammography screening where I have a good story to tell you, which is we are moving to the next stage in that.

If you'll refer back to the grid -- quality at every level, up in the -- among the process measures are the HEDIS step, which includes mammography screening, which is a process measure.

But of that, you see we've launched a project to determine the stage of detection of breast cancer when it occurs. That's an intermediary outcome. It's not a final outcome. But it's an important one. It tells you how good a job the system is doing to prevent cancer from advancing beyond the very first stage. And I really appreciate your question because it's exactly what we need to do more of. And it's very costly because of

the data involved.

MR. KERR: Any other questions?

MR. ARMSTEAD: Let's go further with that example. The stage of breast cancer detection, why wouldn't you go forward to determine if in fact a stage one breast cancer and said "Well, how are those individuals with stage one breast cancer being dealt with?"

I think that's an important delineation because it clearly looks at -- certainly with claims status, we could basically best evaluate from a laboratory perspective. It's certainly evidence that although the literature showed that if you take women who were 50 years older and look at the studies and that as it pertains to a specific category of women on the stage one disease, that lumpectomy is as good as -- but the data was the -- the claims data was not reflecting the decrease in the disease.

So I'm saying I don't think it's adequate enough for you to stop there, that I would encourage that truly the outcome is with spectrum to what is being offered to the patient in the most comprehensive educated situation and what is the outcome of that.

DR. HOPKINS: I am in agreement with you. And I'm happy to say that, while it isn't written there, a component of the stage of breast cancer detection project -- measurement project is what form of procedure was used.

Now, what I thought you were going to ask me was "Well, what about the ultimate outcome, which in terms of cancer therapy, it's usually five years disease-free is survival the clock. And I think that's something we ought to be reflecting. The clock will have to start ticking now, and we won't know for five years. But I think one needs to go all the way through the spectrum.

MR. KERR: The next question?

MR. LEE: In terms of the PBGH member companies doing the negotiating -- as I understand it, when you have a whole group with standard medical package --

DR. HOPKINS: One standard methods package.

MR. LEE: -- does it look at the plan requirements related to the dispute resolution? Do you have an element of that? Not just the benefits but how services are provided to resolve disputes?

DR. HOPKINS: I'm ninety something percent sure that's not my area. So I can't call it up in my mind as to what all is in there. But that is important. Dispute resolution is important to the employers, you can be sure.

MR. KERR: Thank you very much, David.

Now we're going to look at the regulatory side of the state of California. As you know in California, we have a financing facilities and providers all looked at by different groups. For instance, DOC does look at the health plan area, as you know, at this point.

DOI looks at the -- plans. In terms of facilities and hospital clinics, that's the purview of the Department of Health Services. And when it gets down to individual providers, be they physicians, nurses, et cetera, that is held by about 32 different boards under the Department for Consumer Affairs.

So we're going to have -- a couple of our next presentations are from people representing these groups. The first is Dr. Mary Retzer, a physician with the Department of Health Services. She's with the state's licensure and certification side. And she's consulting for them and will talk about it.

As we go through this, the way this thing is set up, it's been sort of vulcanized and so on. Managed care is integrating all this into one structure. Deals with health plan facility groups, facilities, et cetera. So one issue you may want to discuss is whether it makes sense having a whole bunch of groups looking what's becoming a --

DR. RETZER: Okay. Thank you. I believe you have a handout that was distributed at lunchtime. This is the first page. "Licensing and Certifications Basic Function."

Licensing and Certification's basic function is as an enforcement and regulatory agency. It is organized into a headquarters office and has 12 district officers which provide direct service to the public.

The program employs approximately 600 staff

and contracts with Los Angeles County, which has another 5 offices and 160 positions to perform work on behalf of licensing and certification in Los Angeles County. The district offices are responsible for all licensing, audits, complaint activities for health facilities in a certain geographic area.

You'll see in the handouts the word "audit" won't be there. The word "survey" is what we use in licensing and certification to mean the same thing that you probably think of as an audit.

The centralized staff meets the demands relating to budgets, training, legal, collections, complainant, appeals, and where the health professional consultants are based. Licensing and Certification's major activities include licensing 30 different types of health care facilities and providers, which comes to a total allege of over 6,000 licensees so that they can legally conduct business in California.

Among those 6,000 there are about a little over 500 general acute care hospitals. There's over 1,000 home health agencies and over 1,400 skilled nursing facilities. So licensing is a state responsibility. The requirements are a state requirements.

Now, another activity is certifying to the federal government that these facilities and providers are eligible for payments under the Medicare and Medi-Cal programs. Thus, certification is a process conducted on behalf of the federal government, and the regulations and

statutes that are used for the certification are federal.

Licensing and Certification is also designated as the agency to certify that individuals have met the training competency testing and other requirements for nurse assistants, home health aids, and hemodialysis technicians. So L&C certifies over 400,000 individuals in these categories. L&C also provides consumer education and provider education to improve the quality of health care.

There are two sources that fund L&C activities? The state government and the federal government. The Health Care Financing Administration, HCFA, contracts with the Department of Health Services to certify health facilities and other provider types such as dialysis rural health clinics which meet the conditions of participation under the Medicare and Medi-Cal programs.

The majority of the work done by L&C is related to this Medicare, 5Medi-Cal certification process. And in this federal fiscal year 1997 reimbursements to L&C for costs associated with certifying health facilities are expected to total over $36 million. This represents approximately 54 percent of Licensing and Certification's total operational cost.

L&C charges and collects licensing fees from health facilities. The two largest sources would come from long-term care facilities and from hospitals. Within your handout there's more information about some of the complexities of that. Your handout also lists all of

those facility types, the 30 facility types. That's at the back of the handout with their definition.

State licensing and federal certification requirements are very specific and very complex. Some facilities only seek licensing because their services are not reimbursed by the federal government. Other facilities only seek certification under Medicare and/or Medi-Cal because there's no state laws required that they be licensed by Licensing and Certification.

L&C investigates over 11,000 complaints each year. These complaints have been registered about the care that's been provided by these various facilities of providers. Approximately 65 percent of the complaints in 1995 were against scheduled nursing facilities. The percentage decreased as far as skilled nursing facilities to 59 percent in 1996.

About 13 percent of the complaints registered in 1995 and also in 1996 were directed at hospitals. About 4 percent were complaints against home health agencies. And then of all of these complaints, once they're investigated, about 50 percent of them, the results showed that the allegations were substantiated.

Skilled nursing facilities constitutes 44 percent of Licensing and Certification' staff workload. In the 70's and 80's serious abuses were identified nationwide in the treatment of some nursing home residents. Nursing home reform legislation let's new laws governing nursing facilities.

Over 90 percent of the 1,400 nursing homes in Southern California are certified for participation in the Medicare program. In order to operate in this state, a nursing home must be reaudited by L&C every 9 to 15 months. The evaluators that perform this are either registered nurses, or their title, called "generalists," which are people who usually have a medical or social service background -- they receive extensive training in the audit process. The process itself is very detailed and complex, and there's much information about the process in your handout. It's very specific tasks that have been developed by HCFA.

As you will note, there's a histogram on page 5 of the handout. Nearly 50 percent of the skilled nursing facilities were cited for deficiencies in developing comprehensive care plans last year. With the deficiencies related to resident dignity, clinical records, and storage and redistribution of food being cited in nearly 40 percent of nursing homes.

In 1965 the Federal Social Security Act was amended to allow hospitals accredited by the Joint Commission of the Accreditation of Health Care Organization, JCAHO, to receive automatic certifications meeting Medicare conditions and participation.

In California legislation was passed to create a joint survey processes that's known as CALS. And this is conducted by the joint commission, along with a California Medical Association Physicians, and L&C

evaluators. And they all participate as part of the audit team.

When the hospitals receive accreditation, it's for a three-year period. L&C staff only enter hospitals for these audits when they participate as nurse evaluator or generalist or when there's a complaint registered against a hospital or -- oh -- when there's a complaint about a hospital or if HCFA requests an audit. They'll request validation surveys, we call them, to validate the findings of the joint commission audit.

This occurs -- their policy is 5 percent of all joint commission surveys, then have a survey conducted by Licensing and Certification, and they're on a random basis.

The handout identifies a number of other agencies which play key roles in the major Licensing and Certification functions such as -- OSHPD has been mentioned here -- is required -- they're approval when the hospital seeks a new license or new building or for remodeling.

Licensing and Certification staff do not review the payor source for anyone when they are conducting audits of complaint investigations. They look at quality of care issues based upon state or federal requirements. Therefore, Licensing and Certification does not have any information on trends related to managed care and quality of care received by a particular person in a particular facility setting.

What has been noted by Licensing and Certification has been the increased numbers of empty medical surgical beds and acute care hospitals, the increased use of lesser levels of care, the subacute home, health agencies, ambulatory surgery centers are now meeting needs that were previously met in the acute care hospital setting. And then we're seeing closure or downgrading at the emergency rooms due to mergers or decreased financial liability.

Skilled nursing facilities are no longer the long-term location for people like they once were. They're actually becoming more of a subacute transitional care facility.

There's been a transfer of residence who formerly were in nursing homes to residential care facilities, which is a type of facility not regulated by the Department of Health Services. Now home health agencies, they are regulated by Department of Health Services. They provide sometimes the skilled nursing care within those residential care facilities. But the residential care facilities has their license under the Department of Social Services.

State licensing regulations were first written over 20 years ago. It's obvious that they do not meet the needs of the changing health care delivery system. But there's been advances in technology. Cost containment efforts have caused more services to be provided on an outpatient basis.

Although there's an ever increasing amount of care that's being provided in the ambulatory settings, the law defining these entities are unclear and incomplete for the current state of health care delivery. For example, urgent care centers and surgical clinics are exempt from licensure.

Licensing and Certification is embarking on a project, then, to make licensing more relevant for all. For consumers and for the provider. The first step in that process has just begun, which is to start the -- initiate the process of analyzing all the current federal and state regulations, the corresponding status use. And then after that, determine which ones are obsolete, which ones are duplicative, which ones are useful.

What we want to do is focus on quality and what role licensing has in setting and enforcing standards related to quality measures.

MR. KERR: What are you finding from your personal experience and experience of your people going out and looking at quality of care facilities? What would you say? Is it good? Should we be concerned? Is there a trend? What are you actually finding?

DR. RETZER: This is going to be anecdotal, then. As I said, there isn't -- L&C was not able to come up with a lot of data as far as tend setting --

MR. KERR: We need better data --

DR. RETZER: Yes. Yes. One of the concerns that I have that hits me off the top of my head is what

Dr. Spurlock mentioned this morning about the variation in physician practice. I'm seeing a lot of variation in peer review, which is really important of -- it's a key part in the quality assurance programs and facilities.

There's a variation between many urban hospitals and the rural hospitals or even urban hospitals where there's now so much pressure in competition that it takes a lot of courage for physicians to really do effective peer review, which is so vital, as there are more ill people staying for shorter times in hospitals.

So I'm seeing that, and I'm seeing that a lot particularly, like I said -- it's in urban but also particularly in rural hospitals where there's few doctors. It's hard for them to be objective and to bring in outside people to do the peer review.

And that translates itself into, then, if there is a problem in the hospital of the patient care, of it being really seriously scrutinized by the physicians in the hospital. It's being done well some places, but there's a tremendous variation of it.

MR. KERR: So some places obviously are --

DR. RETZER: I think -- when I talk to the medical staff about this, they feel -- there is a lot of pressure that -- pulling them not to do as effective a peer review as they know.

When we were all in medical school, we all did -- went to mortality and morbidity. And one of the

real strengths in medical school and your training is really careful review among your peers. So there are learning opportunities for -- so that if mistakes are made, everything is scrutinize so that mistake is corrected.

MR. KERR: So that's not happening as much as you'd like?

DR. RETZER: Right. Concern in the nursing home level is that the staffing is -- there's so much turnover of staffing. And trying to get by with the lowest trained people, who if not -- who have this tremendous turnover. There's -- most nursing homes have their nurse aide staff turn over completely in one year.

So there's not any -- so there's real concern. And then that translates into patients not having continuity of care. And so we find problems that result from that.

MR. KERR: Any more questions?

MR. RODGERS: Have you considered certifying specialized centers like burn centers? As you know, we're going more and more toward centers of excellence, and they're creating a focus for all the specialists, et cetera. What are your plans in that area?

Number two, are you concerned about the nursing skill level in the acute care setting as well as nursing hour ratios? Are you seeing major changes in that?

DR. RETZER: Well there is -- some of it is pretty well tied -- there's some staffing ratio that's

very restrictive and very set. And so they don't get a lot of leeway with some of that. Yes, there certainly is a trend to try, in some hospitals, to bring the level of nursing quality down. And you -- and you -- but the complaints -- I just -- I hesitate to give you generalities when I don't have a lot of data to back up as far as the severity.

The level of citations, which is levels of severity in the nursing homes, have stayed about the same in the last couple of years as far as cases cited where there was imminent harm or substantial probability that death or serious physical harm would occur. It's been about this level the last couple of years.

MR. KERR: You do the audits; right?

DR. RETZER: Well, we do the audits, yes.

MR. RODGERS: The specialty.

DR. RETZER: Well, what is being considered -- I don't know about that. I would have to get back about that information about whether they're looking at -- you mean certifying or licensing specialty? Do you mean certified as well as levels of excellence?

MR. RODGERS: That's correct.

DR. RETZER: Yeah. That's definitely being talked about. It's not just having it be the negative. Pretty much what we do now as the enforcement is negative but to reward those who do well. There is something in nursing homes called the "best practice." And they are singled out, and there's awards given every year

identifying the nursing homes of best practice.

MR. RODGERS: Are you looking at clinical outcomes specializing with the specialty centers --

DR. RETZER: The HCFA -- the overregulations that has to do with nursing homes is very interested and emphasizes outflow. So the trend tends to -- it tends to be always outcome oriented. That's the tenor of everything that's been going on.

DR. KARPF: On the peer review process, that may be a problem in some institutions, but I think other institutions have gotten aggressive about that. Some of the leading institutions around the country not only do internal review process but actually benchmark against national standards to see if in fact they provide care at the very best levels of care.

So I don't think the audience should be left with the feeling that in fact there is no regulation in the medical community.

DR. RETZER: I agree with you. It's where there's a variation. There's a broad variation. But there are places that are doing absolutely excellent.

MR. KERR: Are managed care -- you said there's variation. Has managed care caused less variation?

DR. RETZER: The variation seems to be because -- as far as the peer review is concerned, yes. There's more variation. Because some hospitals are very effective, but there's other ones who sort of yielded to

the competitive financial pressures. And some doctors will say it's too -- it's too much of a headache. Because I get too much flack, if you will, from my competitors.

It's all tied up too much into competition. And it's very challenging and courageous and difficult for physicians to put on the hat of a medical staff member or leader and take off their hat as far as their private practice competitor. There really are two distinct functions. And it's difficult sometimes for some physicians to be able to make that distinction. Some others do it well.

MR. NORTHWAY: In regards to what the last speaker talked about -- you know in the private sector a lot of the quality data is being collected. Have you thought of any ways to which your organization can work with the private sector in reducing the duplication of number of people coming in?

DR. RETZER: That's part of what this project is. If one starts get into quality one immediately starts getting into data. And then one has to figure out how to get the data. And when you know that there's private -- it's being done in other avenues, one of the keys is going to be -- is to collaborate.

And I'm supposed to be developing a liaison with professional groups. Because you want to first -- you wanted to start getting in the project, but then you have to develop a structure so that as there's advances made that you can continue to respond to that and be much

more efficient at what we do and really be clinically relevant. But the data element of it has to be tied in with private. It's so expensive to try to do it.

MR. KERR: Thank you very much, Mary. We're going to go on to the next -- we have 13 medical boards. A couple of them are here talking about their experiences on the private practitioner level.

From the Medical Board, we have three people. Dr. Hsieh, Dr. Shumacher and Karen McElliott. I'll ask you to be very brief and cut to the chase if you can. You have eight minutes.

MS. McELLIOTT: We will be brief, but we have important things to say as well.

MR. KERR: Tell us some of the important things.

MR. HSIEH: Dr. Enthoven, members of the task force. Hello. My name is Stewart Hsieh, and I'm the president of the Medical Board of the State of California. My purpose is to introduce Dr. Alan Shumacher and Dr. Karen McElliott. Dr. Shumacher is a retired neonatologist, serving on the Division of Medical Quality. He's our immediate past president of the Medical Board and serves as an elected officer of the Federation of State Medical Boards of the United States.

Ms. McElliott is secretary of the board, past president of the Division of Medical Quality, past president of the Board of Podiatric Medicine, Commissioner of the Jack Murphy Stadium in San Diego, and like myself,

a member of the public at large on the board.

As for myself, I'm transactional lawyer, not a doctor, who practices in the City of Los Angeles. Also here, I'd like to acknowledge, is Carol Herbitz -- Dr. Herbitz is a member of the board -- and the executive director, Ron Joseph, for the Medical Board.

We're here to emphasize the wide range of representation of people on the Medical Board and its commitment to the cornerstone of any medical care, the doctor-patient relationship.

While you're task force has been brought together to deal with recent issues of health care delivery, the board has been dealing with the fundamental issue of consumer protection and the practice of medicine since 1876.

And now I'd like to turn it over to Karen McElliott.

MS. McELLIOTT: Thank you, Chairman Enthoven, members of the governor's Managed Care Improvement Task Force. I'm Karen McElliott. I'm secretary of the medical Board of California. With me, who has been previously introduced, is Al Shumacher, immediate previous past president of the board.

We appreciate the opportunity to present the perspective of the Medical Board regarding the important issues which this task force is addressing. The Medical Board is charged in its mission to protect consumers through proper licensing of physicians and surgeons and

certain affiliated healing arts and professions and through the vigorous objective enforcement of the medical practice act.

Consistent with that charge the Medical Board has actively involved itself in the ongoing public policy discussions concerning the evolution of the managed care model of health care delivery. Mostly, notably, through its quality of care in a managed care environment committee that was established in April of 1995.

Much like your task force, this committee of Medical Board held a series of public hearings throughout the state. The Medical Board heard of the many successes which have grown out of this health care delivery model of the frequent frustrations which have been encountered by all participants and regrettably of the harm that can and does result from some management practices which this system embodies.

Indeed, one constant in the ongoing discussion of the evolution of managed care is that the user of services is afraid, often confused, and sometimes angry. The concerns which we hear expressed about managed care are concerns voiced by the public about the essential question of whether or not they will get care. The underlying validity of these fears is almost secondary to the reality of their widespread existence.

You may sit here for meeting after meeting, debating whether or not care in managed care environment is being appropriately delivered. The crisis of

competence which expresses itself daily in the public arena answers that question in a more fundamental way. The public believes that they are at risk of receiving substandard care or having it denied altogether. And they are unsure that any entity exists to protect them.

The Medical Board of California calls on this task force to recognize this breakdown in the public's trust and to offer concrete answers based on a recognition that those with the preeminent interests in this public debate are the recipients of the service, the patient. For them managed care is something other than simply an alternative to fee-for-service.

They need to know that the delivery system will be consistent with the medical judgment and care decisions which result from a sound physician-patient relationship. For them ways must be found to assure the decision provision of best services without reigniting excessive medical inflation. Patients must be return to the care of their physicians, and physicians must be free to use their medical judgment to provide quality health care.

The Medical Board of California does not suggest that has absolute answers to these questions, but it does believe an important component of the final answer is a regulatory mechanism appropriate to serve the public good, one which has the interest of the consumer as its primary mission.

As I have stated before, this is the mission

of the Medical Board of California, an agency which is ideally structured to address the interest of the users of health care services.

The Medical Board by its charter and by its experience speaks strongly in support of the proposition that the patient's best interests must be the mission of the regulatory entity charged with the oversight of the managed care industry.

The Medical Board of California believes that to begin a serious response to these issues requires that the recipient of the services, the patient, must be returned to a central position in the health care delivered equation.

In recognizing the individual as the primary beneficiary of its role, the mission of the Medical Board, to protect the public, stands in contrast to those governmental entities currently responsible for the regulation of the corporate delivery of health care.

The adoption of this principle can be an important first step in the movement toward a system which will be embraced by the users and the purchasers of health care alike.

The Medical Board believes that experience in physician regulation has provided it with considerable insight as how large professions or industry can be regulated in a manner which is not so intrusive as to undermine the industry but is consistent in its regulation so as to assure the desired outcome of public protection.

This is best provided through the structure of the board where appointees to that Board are understood to bring a commitment to the public protection and the quality delivery of health care. This history, this commitment, the experience argued strongly for the placement of the healthcare delivery regulation under the regulatory responsibility of the Medical Board of California.

As health plans become integral to the decision-making process of what benefits of medical science will be available to what patients, the name must also be held to the society standard of public protection.

Let me briefly explain the makeup and function of the Medical Board of California. There are 12 physicians and 7 public members appointed to the two division of the board. The division of licensing and the division of medical quality. In a moment I will describe them briefly. What is most important in this makeup, however, is the incredible diversity of the membership which provides for a broad based understanding and representation on public policy issues.

There are attorneys, private practice physicians, business owners, medical educators, community leaders, and medical administrators among the membership providing the serious -- the capacity for serious consideration of issues from a variety of perspectives.

MR. KERR: You've just about reached ten minutes. It's good to hear background about you're doing, but what do you want us to do and think about?

MS. McELLIOTT: We feel like the regulation of the managed care facilities should be in the hands of the Medical Board. We have the structure that could provide that. We have the division of licensing that oversees the work force. We have the division of the medical quality that deals with the enforcement. We have a structure that is already in place.

And one of my concluding remarks that I was going to be able to make to you is that we are almost -- the responsibility of the governor and the legislature -- we have already been given that responsibility in that charge to take care of the public, and we believe that the health care management industry should be under that purview.

MR. KERR: So what do you do and what have you done? What kind of results have you gotten so far? You've been in existence since 1866?

MS. McELLIOTT: What do you mean, what do we do? We license all of the physicians in the state of California, which are about 86,000, and we deal with the enforcement of physicians that do not meet the standards of the Medical Practice Act.

MR. KERR: I'm looking for outcomes. What circumstance do you find problems with? You've given us a theme, but what's the knitty-gritty of what you're

actually doing?

MR. HSIEH: I have a confusion with your question as far as what you say is the nitty-gritty. The issue I think is that the task force is trying to come up with an answer to where to put managed care regulation or what to do with -- where oversight should be. And you have a charge that needs to be addressed where we have an agency --

MR. KERR: -- the functions which would be -- what should be the functions of the oversight group?

MR. HSIEH: That's easy enough. Why don't I have Dr. Shumacher address that.

DR. SHUMACHER: The oversight group has to look carefully at the critical interfaces of patient care. And that is the interface between the physician and the managed care organization and between the physician and the patient. That is what determines the quality of care in this kind of setting.

And it is of extreme importance to the patient, and I can't repeat too much times that this entire effort must be centered on the patient. That's where the outcome is. That's to whom the outcome is most important. Now, we have to take a hard look at how you're going to do this --

MR. KERR: There's no disagreement -- the group agrees. But how do you do it?

DR. SHUMACHER: Here we have an agency that has been in this business for a little over 100 years.

And we have proven results. We have been doing our job effectively for many, many years and have the figures to prove it. We have a degree of expertise that it would take other departments, other agencies, years and years to try and accomplish. And I think that's the basic message that you need to take a very hard look.

We're already charged with the protection of the consumer. That's our job. And we're charged with doing that by protecting the quality of medical care. That is what we do.

DR. ENTHOVEN: Well, Doctor, the problem with that answer is also we've seen health care insurance premiums rising at such a rate that they double every five years. We've seen wide variations of the medical practice from one part of the state to the other. In short, Medicare beneficiaries have five times as many prostatectomies and other ectomies as another part of the state and so forth.

So I think what Clark is getting at is there have been major mounting problems which in fact managed care has been trying to address. The consumer also has interest as the payors ultimately. This comes out of people's pay and taxes. So we're looking for some systemic approach.

DR. SHUMACHER: You're absolutely correct. Managed care has in fact reduced the cost of care and, I think, put some kind of a cap on the runaway inflationary costs that we were experiencing in the past. But there is

a balance point between being completely cost centered and being completely care centered. And one must find that balance point that's in the best interest of the patient. I think an effective equality of care system is a vital part of an overall system that will accomplish that.

MR. RODGERS: Is there any other state that uses the Medical Board as oversight of the managed care or health plan industry? Any other state in United States?

DR. SHUMACHER: I believe they are looking at this in the Florida legislature. But I don't think that's been accomplished. The short answer to your question is no. This is unique suggestion and a unique opportunity.

DR. ALPERT: Just a quick comment. I think, Alan, all of the things you've listed are tremendous arguments to do what was just suggested. Because they have all evolved -- the runaway train effects that you said a number of them have evolved in an environment where obviously regulatory agencies have not been able to control that to the satisfaction you would like. They're suggesting that an agency exists that might be able to do that by virtue of its expertise. And, therefore, the transfer of that regulation to that agency may help control it.

MR. KERR: Another question?

MR. LEE: I'm not a doctor. I raise this with all due respect for the doctors in the room. The vast majority of -- one of the jobs that you do is there

are some bad eggs, so to speak. In terms of Dr. Clark's question which was about statistics -- sort of a picture that, given the 86,000 doctors, or some number like that, how many of you actually remove their license because they've not provided quality care? Because the doctor-patient relationship is where some of the problems can be as well as where many of the solutions are.

MR. HSIEH: Unlike what you read in the newspaper, the number is very low. You'd be surprised that the actual removal is about one percent, total. And we license the state of California. One sixth, approximately, of all the doctors in the United States. We are in the leading edge of regulation of medicine.

And you should also -- the task force should realize, you know -- it's amazing. All the other agencies that may be brought before this task force -- who does the consumer go to? And who do the other agencies turn to when there's a managed care issue? They come to the Medical Board, even for issues that we don't even address, whether it be physical therapy insurance issues. We get the calls. Hundreds of thousands of calls a year. So it's a natural place for it to come anyway. And we've already staffed it up.

MS. McELLIOTT: Even in the managed care. We end up getting the phone calls for any of the malpractice -- things that are happening in the managed care industry. They call the Medical Board, and we have to turn them over to the Department of Corporations. No

one realizes that Department of Corporations is the entity that is their protector.

MR. LEE: A follow-up on that, the one percent is 860, then? Did I get the 860,000 number correct earlier?

DR. SHUMACHER: Let me clarify that. Of all the physicians currently licensed in California -- that's about 103,000 -- roughly 77,000 practice within the state of California. Of that number of those practices at any given time, about one percent are disciplined.

Now, discipline has more meaning than just removing a license. That is the death penalty. The ultimate penalty. There are many forms of discipline because our job is to protect the public, not to be a punitive agency, particularly. In protecting the public, we impose restrictions upon practice and do a number of things prior to taking the ultimate step of revocation of license.

MR. LEE: Just to follow up on the note about the Department of Corporations, if the physician has done the care that may have been inappropriate care, there may be a complaint to the Department of Corporations because that's in the cost of the health plan. But shouldn't that complaint come to you because that doctor is practicing medicine --

DR. SHUMACHER: Absolutely.

MR. LEE: Is there a cross referral at all?

DR. SHUMACHER: I hope so. We make

referrals to the Department of Corporations. I believe they --

MS. McELLIOTT: We don't know.

DR. SHUMACHER: But we don't know. That's right.

DR. ALPERT: If I may add to Clark's question the specific statistics about -- specific disciplinary statistics in their breakdown are available and are publicly published Those are easy. The statistics that you won't find and that is worth bringing up that may sort of lay the stage as to why this presentation is having the flavor it is, is that the Medical Board has 1,000 physicians, consultants, employed in the network to review quality things. These physicians are all precredentialed for their ability to review these things. It's the network that's been in place for a long time.

MR. HSIEH: We also approve and certify certain medical schools and -- in the state and outside the influential jurisdiction -- let's say out of the country.

DR. KARPF: There's no question you have extensive experience in evaluating individual competences, but that hasn't been brought to us as the crux of the issue. The crux of the issue that was brought to us is how does the systemic process impact the decision making? We haven't been told that HMO's or managed care plans attract poor physician. It's the interaction between the economics and dynamics of the relationship that's been the

issue. And that's not an area that I'm familiar with as your organization having a lot of experience with.

DR. SHUMACHER: No. In fact, we can't because we're not permitted by law to do that. But what we would envision is a system that allows us to look at the relationships that would exist between those individual physicians and the organization to be sure that there's nothing in that relationship that inhibits the physician's ability to do the high quality, good job that both physician and patient want to see.

So it's important to look at that relationship as well as the relationship between the physician and the patient, which is something that we now do oversee directly by statute.

DR. KARPF: One of the problems that arises is we're starting to make decisions based on populations as opposed to -- not as opposed to individuals, but their population-based values as opposed to individual-based values. And oftentimes there isn't a right answer. Because there's great controversy as to whether a process or a service in fact is beneficial or isn't.

DR. SHUMACHER: You're absolute right. And as one who spent thirty-plus years as a neonatologist, who knows the difference between looking at population-based statistics and standing at the bedside with a sick one-and-a-half pound neonate that you're entrusted to care for, yes, there are some very difficult decisions to be made there. But we like to think that when error creeps

into that system, as it invariably will, because no system is perfect, it will be on the side of safety.

MR. KERR: J. D.

MR. NORTHWAY: I'm not sure what you're proposing. Are you looking at yourself as sort of a super agency that overlooks quality and access? Are you also looking at -- you would license health plans? You would do the kinds of things of the Department of Corporations? What is it your proposing to us?

DR. SHUMACHER: To be more specific, I think what we envision is -- and I would emphasize we have at this moment a general vision of this for you to look at. And that is we would envision ourselves in some way -- I shutter to use the word "credential" -- but in some way providing a credential or a license involving the quality of care issues.

I don't think we are the appropriate agency to get into the issue of financial responsibility of the organization or whether it follows the corporate rules. We have very competent state agencies that already do that part of the job. It's the quality of care issues that concern us.

And, yes, I believe we are the agency who can do that best because we've been doing it for a lot of years successfully and because we are used to dealing with the complex issues that come up.

MR. RODGERS: Just a quick question. Have you looked at the conflict of interest issues and the

impact of taking over this responsibility will have on your ability to regulate other parts that you currently have responsibility for? Specifically, you're now dealing with a payor, and any sanctions of a payor could affect -- could have conflict of interest, either financial or indirect.

There are a lot of implications. Have you really looked at why you're separate now and your check and balance, if you will, on the rest of the system?

DR. SHUMACHER: Well, I don't think we've looked specifically in the way that you've mentioned, but I will say each one of us, as we come to the Medical Board and make the decisions that have to be made in regard to Licensing and Certification and discipline issues, we take off all our other hats.

MR. RODGERS: You are dealing with individual practitioners where you don't have a financial interest -- as physicians, as lawyers, et cetera. You're going to be dealing with very large health plans. And it will create complexity. I'm just asking have you looked at that?

DR. SHUMACHER: It is complex. We have not looked at it specifically, but we do already deal with institutions in the sense that Mr. Hsieh had mention, and that is with the medical school.

MR. KERR: Thank you very much.

Our next speaker is Geri Nibbs with the Board of Registered Nursing.

MS. NIBBS: Good afternoon, Mr. Chairman and

members of the task force. There is only one of me here today. I will try to keep my presentation very short. When I was asked how much time I would need, I said I'd need only about an hour." Only kidding, though. I will cut my presentation to a minimum.

I would like to thank you, the task force, for inviting the Board of Registered Nursing to speak today before you on the issue of managed health care and the role of the Board of Registered nursing as a state regulatory agency.

Our executive officer, Ruth Ann Terry, was not able to make it today because of conflicting events.

Like the Medical Board, the Board of Registered Nursing is charged with protecting the consumer. It is responsible -- the board was established by statute to interpret and enforce the Nursing Practice Act, which is the rules and regulations pertaining nursing education, licensure, practice, and discipline in the state of California.

We have a handout. A brochure. If I leave it with you, you will read it at your leisure, right? So I don't need to belabor that and go over each of those activities with you. But in saying that, I don't want to minimize the role of the Board of Registered Nursing or the role of registered nurses themselves in providing quality health care to California's diverse population.

I believe each of you, by the fact that you

invited us here today, are acknowledging and recognizing that registered nurses are a key part of the health care delivery team. Is that a fair statement?

Okay. That aside, then, I will not, as I was originally planning, go over each of the items that the Board of Registered Nursing is responsible for doing.

About four years ago -- well, fall of 1994, the Board of Registered Nursing convened four forums across the state to get information from the public about issues that were -- that were of concern to registered nurses, but more important, to the citizens of California when it came to the regulation of registered nurse.

Unfortunately, when we had those four forums, the majority of representatives were registered nurses. But they did provide us with some very telling and compelling testimony about what was going on in the health care delivery system at that point in time and, I believe, is still going on at the present time.

As you know, the practice of health care, the practice of nursing, and concomitantly the quality of nursing care is being impacted by a number of factors, including the rapid development of technology, the shift of focus of care from acute care facilities with the growth and the subacute home care and long-term care arenas and also changes in the health care delivery insurance market, including the transition to managed care systems.

The concerns that were articulated by the

registered nurses at the forums that we held revolved essentially -- about 75 to 80 percent of the registered nurses who testified talked about the substitution of licensed registered nurses, LVN's, with unlicensed assisted personnel. And this really was the issue. We're talking about the down sizing the skilling, deskilling of individuals providing care to patients.

What was the board's response to that? Our initial response was the development of an advisory statement, which if you're interested in receiving, I can provide to each of you. We are in the process of putting that advisory statement into regulation so we won't have underground regulations as we've been told you cannot have. We should be noticing those regulations tomorrow.

Yes, it's taken us a long time. One of the problems with working with a regulatory agency is you can't do things as expeditiously as you normally would like to do.

Some of the activities that we were told that unlicensed individuals, untrained and unqualified individuals, were doing which was traditionally the practice of registered nursing was assessing patients, making nursing assessments, triaging the patients, and then providing care to patients, which was at a level that they were not prepared to do.

The registered nurses in those instances were put in a untenable position. They mandated by our law by the Nursing Practice Act to provide safe, quality care and

to function as the client's advocate. But with the changes that were going on, the nurses were concerned that, one, they would not be able to provide quality nursing care as mandated and, two, that they would not be able to, as I indicated, provide quality care, but they were also concerned about their individual licenses.

That was not their overriding concern, but certainly a concern, because they worked hard to get their license and put in the position of where a patient is harmed as a result of who was providing care.

This board, as a regulatory agency that licenses the individuals, would look to them, and they were subjecting their licenses to disciplinary action.

Not being satisfied with just the information that we were receiving from registered nurses -- because, of course, they had a vested interest in what was going on -- the board did convene in the spring of '96 to focus groups specifically of consumers of health care organizations, voluntary health care organizations, and other consumer groups.

The focus group -- the input that we got from those participants indicated that, in general, R.N.'s were viewed as hard working, caring individuals. So participants rated R.N.'s as being good at educating consumers about their care and were seen as having the skills necessary to provide, blah, blah, blah. That's in the NBR report you have in front you.

So I'm not going to go on reading from that

article other than to say concerns that were voiced by those participants were that the economic issues may hamper nurses from taking a strong position on patient advocacy, that patients are often too ill, too lacking in knowledge, or too limited in communication skills to advocate for themselves, which then makes the role of the registered nurse even more important in that process.

In terms of recommendations that our board might present to this committee for consideration, we certainly are not advocating that we take over responsibility of regulating managed care, thank you very much. Don't even want to go there this afternoon.

But if the task force should recommend any type of regulatory board or oversight agency, we would strongly encourage you to ensure that, one, consumers are represented on there, but, two, that all health care professionals are appropriately represented, including registered nurses.

We would also have you look to the issue of resources that would be available to any regulatory agency that would have responsibility for regulating managed care. Particularly, there should be registered nursing staff functioning as resources. Okay? Not just physicians. Certainly, physicians are important roles. But registered nurses are also vital participants in the health care delivery.

There is one other issue that may be somewhat unique to managed care that I would like to bring up at

this point in time, and it has to do with practice barriers for advanced practice nurses. Our board does issue certificates to nurse practitioners, nurse midwives, and nurse anesthetists.

It's been brought to our attention that there may in fact be statutes and regulations which prohibit nurse practitioners and other advanced practitioners from providing the quality of care which they are capable of doing. I.E., there is access issue in that the managed care agencies and facilities are not mandated to publicize and do not always utilize their advanced practice nurses.

That's the end of my planned presentation. I'm here to answer questions if you have any.

MR. HIEPLER: You said economic issues often prohibit advocacy and sometimes care. I'm wondering if your information compares and contrasts as specific HMO patients versus the one down the hall who might have it painted their own way. Is this a phenomenon of managed care, or are you just seeing it in all aspects of care?

MS. NIBBS: We can't say that's unique to managed care because we did not ask that particular question.

MR. KERR: Terry.

MR. HARTSHORN: You mentioned -- I forget the term you used -- but that R.N.'s not as many -- I guess substitution of non-licensed personnel. Where is that taking place, what part of the industry is it? Acute care?

MS. NIBBS: Across the board.

MR. HARTSHORN: What about physician officers? When you say across the board, does it include everything? Medical groups --

MS. NIBBS: It's happening in physician's offices and across the board. Physicians offices, though, don't necessarily have registered nurses in them. They have medical assistants, who sometimes are confused with nurses. The term "registered nurse" is a protected title. You have to be licensed by our board in order to use that particular title.

The word "nurse" is not protected. So when a consumer goes into a physician's office or outpatient department and are receiving care, they assume that the person who was providing care who identifies him or herself as being a nurse is either a registered nurse or a licensed vocational nurse. So there certainly is confusion on the part of consumers related to that issue.

MR. HARTSHORN: What are the statistics in terms of this ratio change? Do you have that statewide basis or any in terms of the number of unlicensed personnel that are being substituted for licensed personnel.

MS. NIBBS: There have been research in studies. But, no, I did not bring that information. But I can try to provide the committee with the information related to the increased use of unlicensed assistant personnel. It's one of the things we have to do as part

of our regulation packages.

DR. ENTHOVEN: One of the paradoxes in this whole thing is what we hear keeps on sounding like there have been massive layoffs of nurses who are replaced with unqualified people.

But a recent study accomplished by Joanne Spence of the Public Policy Institute of California, who is well-qualified on the subject, purports that employment of R.N.'s -- in terms of full-time equivalence adjusted for all this stuff -- in California rose rapidly through the 80's and into the 90's and flatend out but did not decrease from about 1993 to 1995.

And it's a real a paradox, puzzling thing that it's possible employment of R.N.'s does not seem to have decreased. So what we hear about this down sizing and substitution, the aggregate data don't support it. Do you know why?

MS. NIBBS: I can't answer why you're not seeing a decrease in the number of full-time equivalent R.N. positions, but I would counter with that the acuity of patients is increasing in the hospitals. You're also seeing simultaneously shortened hospital stays so that registered nurses are in fact supervising more unlicensed personnel and held accountable and responsible for doing everything that they did in four or five days to one or two days. I don't know if that's helpful for you.

DR. ALPERT: Alan, in reference to this question and in Mark's question too, which demonstrate a

disconnect, I think, between the theory and what really goes on in a hospital or in terms of nurses taking care of patients, I think if you both went to -- I'll take the San Francisco Bay Area -- every hospital in San Francisco and spent an evening, then you would also not be able to explain the statistic view quota with regard to the employment not going down of R.N.'s. But one fact would hit you in the face, and that is the structural nature that's being -- that's being demonstrated here in terms of the lesser nature of expertise that R.N. is required to have expansion of her job responsibilities. And then you would be puzzled by the question, like I am, and she wasn't able to answer either. That puzzles me.

MR. KERR: Any more questions for Geri?

Okay. Thank you very much.

Our final presenter is Chris Selecky, former president of Major Managed Care Organization in California, and she'll give us the perspective of a person who was regulated.

MS. SELECKY: I want to thank you inviting me here and being the last speaker. It's a great position to be in. I'll try to be brief, and in order to do that, I'll read my notes so that I don't drift off.

As the former president of one of our large of health care plans in California, I was asked to address you about the impact of the fragmentation that our health care system has had on the ability of our regulator to ensure consumer protection.

I think that one of the reasons I was asked as a former HMO person is that I could probably offend anybody in the room, and it really wouldn't matter to me. But I do want you to know that my remarks are really founded in my deep belief in the founding principles of managed care and of the HMO industry in the profound hope that we can return to those founding principles.

And also they come from an understanding of the rapid evolution of what's happened in managed care and in health care and the fact that in a lot of areas, we just have not adapted fast enough to those changes in order to meet the consumer's needs.

When I first started working for an HMO almost 16 years ago, the dominant model was a closed system with employed physicians working in staff or group model facilities. Much our specialists were in-house, as well as pharmacies and other services. And the primary care physicians had every incentive to do what was right for the patient. But no incentive to over-utilize.

Because there were few competitors, our members stayed with us for the long haul. And as a result, we had the incentive to make investments in the programs to contain costs by making improvements in our members' health. The federal and state HMO laws and regulations were defined with this type of model in mind and were easy for us to adhere to as a staff model HMO.

We called ourselves a health maintenance organization, and our objective was to remove barriers to

care and provide our members with the tools they needed to maintain and improve their health.

Because our model was so successful in reducing health care costs, large employers and government entities, such as Medicare and Medicaid, fueled our growth. In order to accommodate this growth, HMO's needed to open their delivery systems to included community hospitals and physicians. The network model became dominant, and HMO's searched for innovative ways to "incentivise" physicians and utilize services appropriately.

But because specialists, pharmacies, lab, radiologists and other services were not part of the same delivery system, the payment structure became fragmented, and the incentives in some cases became as perverse as those in the fee for services.

Because there was little differentiation in benefits, premium, and provider networks, members began switching HMO's yearly based almost solely on price. As a result, we lost a financial incentive to make investments in our members' long-term health. Even the names of it changed. The things that used to be called "health maintenance organizations" are now "health plans," eliminating any mention of health maintenance or even organization from the conversation.

In a few short years, the system moved from one which was focusing on managing care to one that focused on managing costs. This has all been happening,

as we are also experiencing the rapid increase in more costly, aging, chronically ill patients, who require patient focus, longitudinal programs to improve their health, and to reduce preventive complications of their diseases. These patients were justifiably very dissatisfied with the current system, and this dissatisfaction is feeling increased regulation, legislation, scrutiny in the press.

Unfortunately, incremental changes being made to legislation and regulations, which still reflect the expectations of the old staff and group model plans. And in some cases the legislation is adding to the problem by removing clinical decision making from the physicians' discretion.

The bottom line of all of this is that while everyone involved -- the health plans, the providers, employers, and other customers, patients, and the regulators -- clearly want to improve our health care system. Consumer protection is not what it could be.

While we could all possibly agree -- and I've heard it time and time again today -- that the most important thing for consumers is having a good outcome. This has been very difficult to manage because all of this fragmentation has resulted in fragmented, incomplete, and often non-existent patient data.

As a result, regulators and accreditation agencies focusing primarily on managed care processes, such as how long it takes to pay a claim or resolve a

dispute or even how many tests were done for a particular condition, while completely ignoring whether these processes resulted in a better outcome for the patient.

This focus required health plans to take on regulatory roles with health care providers, which sets up an adversarial relationship and continues to contribute to the discord in the system.

At my HMO we had to deal a multitude of regulators, quasi-regulators, and accrediting agencies. We had DOC, DHS, DOI, JCAHO. All of the professional boards, including the ones that were represented here, plus the lab, the radiology, NCQA, PERS OPM, PBGH, and then, of course, all the large employers who required us to provide HEDIS.

Each group had their own agendas and their own measurements for quality. None of these groups, I feel, pushed us any closer to measurement of patient outcomes. The governmental regulators were measuring our compliance with the law, which was for the most part outdated. And they tended to be very process and fiscally oriented. And the bulk of the reviewers were lawyers who had no clinical experience.

Employers got a little bit closer as they started to demand data on clinical indicators like HEDIS. But, again, this information only focuses on transactions, not patient outcome.

This fragmented, duplicative regulatory process served only to increase our administrative costs

and did nothing to improve the quality and care. We had to spend weeks pulling files, organizing meetings, reviewing regulations only to have to do it again a few weeks later for the next audit.

If the results of this were improved patient outcome, I would say all of that activity was worth it. But I don't think the results bore that out.

If you ask me how the system should work, I won't presume to tell you how. But I would suggest you look for an industry or an outcome which we can all agree is well-regulated and use it as a template.

An initial thought would be to look at how well California has done in the management of their quality. In the 16 years I've lived in this state, air quality has continuously improved to the point where you can actually notice it.

The components of this program that might be applied to managed care are it's local boards to ensure recognition of regional differences because health care is a very locally focused business. Its use of scientists and other experts knowledgeable in the field as regulators -- and I might include consumers in that list -- and its focus on improving a clearly measurable outcome rather than just process.

When I left the HMO two years ago, I made a decision not to return to that -- managed care because I felt the initial promise of managing costs through managed care had been lost. The increase in consumerism and -- in

communications technologies, such as the Internet, have created an atmosphere which could be conducive to reestablishing and reengineering the doctor-patient relationship -- patients to take more responsibilities for their healing and using data to measure improvement in clinical outcomes. A streamlined, non-fragmented regulatory structure and consistent enforcement will greatly enhance that environment and allow more -- and improved care management.

Thank you.

MR. KERR: Questions from the task force?

MR. HIEPLER: You described perverse incentive that you had seen as being on the inside. Can you describe what those are in reality for us to understand.

MS. NIBBS: I could give you one example, which is that very frequently providing a patient with drug therapy could avoid a hospitalization. And yet when you have drug costs in one silo and hospital costs in another silo with different people responsible for managing those two, you often get the person responsible for the drug costs not wanting to give that drug, and the result is the hospitalization.

That's just an example of what that fragmentation really is. Health care is a lot of puts and takes and, you know, spending money up front to save money down the line, and I think that a lot of that has gone away.

MR. KERR: Any more questions?

MR. CHRISTIE: The one question I have is do you see the health plan's role as managing benefits or managing medical necessity as a medical decision as opposed --

MS. SELECKY: I think all of you are here to answer that. My preference would be that HMO's or managed care organizations use the power of their membership, their millions or thousands of members, to aggregate data and look at outcomes research and, you know, really try to move the ball ahead in terms of providing doctors with information about how to improve the treatment plans, while at the same time, using their large size to be able to go out and market their programs to people all across the country.

So I think it may be a combination of the two. But I don't -- I think the time has passed except for a few health plans like Kaiser. You know, I think the time has passed where the HMO's are the deliverers of care. I think they need to move into the information age, get out of the industrial age, and start using the power of information to improve the quality of health care.

DR. ENTHOVEN: Thank you very much.

We had originally planned to spend time going over the survey we did internally on the issue. We don't have time. I want to say that we're going to do it August 8. This was the survey compiled June 20. But I want to mention there were four areas of consensus to keep

in mind. Refer to the information you've been passed out.

There were four questions a general consensus was on. The first one was "Do you believe the current regulatory structure is working optimally?" And 21 of 24 respondents said "no."

The next consensus on a question we arrived on was "Do you think HMO's should be regulated by the same agency as other managed care entities?" 20 of 24 people said "yes."

"Do you think the same regulatory authority should exercise oversight authority over the delivery system, in other words, medical duties and so on, as well as health plans?" 20 of 24 people said "yes."

And the final we have a consensus on, "In which organization do you prefer the authority for health plan regulation to reside?" And 13 of 24, which a majority said a new agency perhaps called "Department of Health Plan Oversight."

We'll discuss this in detail August 8. Please think about your thoughts about these.

I want to make a couple of announcements. One is for members of the task force now. I trust you have received an authoritative copy of the treaty that we negotiated this morning. If anyone asks you what was agreed upon, the document is here.

Secondly, we want to announce that there will be an expert resource working group meeting on the physician patient relationship August 25 from 1:00 to 4:00

P.M., at the U.S.C.W. Local 770. I want to thank John Perez for making his facilities available to us, the fourth floor meeting room, wheelchair accessible. There are copies of this.

630 Shatto Place, Los Angeles, California, at Wilshire and Vermont, off the Vermont exit of the metro rail.

Copies of this announcement are in the back of the room, and they're available for anyone who wants to attend that meeting. For task force members, we will also include this in the follow-up information so that we will have it.

Now, we will proceed to the public -- I'm sorry. We will first adjourn the business meeting. So the business meeting is hereby adjourned.

(Whereupon the proceedings were adjourned at 4:00 P.M.)

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DR. ENTHOVEN: Now the public meeting will come to order -- the public hearing. Task force members who need a break will be authorized by their chairman to sneak out one at a time.

We have a very challenging situation here. I want to appeal to the members of the public who have kindly and generously given of their time to come and speak, to respect the time of other people who also want to speak. Because we have a very large turn-out of people who want to speak who sent in speaker identification cards. And we really need to finish promptly at 6:30 this evening.

A couple of other things to say is -- to the audience is that our interest is in systems reforms. We know that there are many failures in the performance of the healthcare system. We know that many people have failed to get the care they needed. We know that many people have been injured by mistakes in medical care.

I've told the task force about a study done by the Harvard University School of Public Health on hospitals in New York in 1984, pretty much a managed-care-free environment, in which they found that 14,000 people in the year 1984 had their lives significantly shortened or were killed by accidents in hospitals. That would be, like, 180,000 people a year in the United States. A similar study done in California a few years earlier in connection with malpractice liability achieved similar findings.

And the sources of that are very complex. It has to do with the great complexity of medical care. And so just the fact that -- we know that the system does fail, and we're seeking to find ways to make it work better.

I would appreciate it, in the interests of those who want to follow you, if what you've had to say has already been said, then to make your marks particularly brief or possibly refrain.

On the issue of the role of the task force in the legislative process, I believe that we aired that thoroughly this morning and negotiated a treaty to wrap it up. So I would appreciate it if we didn't hear more about that unless you have something that's new and significant.

All right. I'm going to have to ask people to confine their remarks to three minutes and ask the task force, generally, to hold their questions to get through this. I regret that I am going to be forced by the circumstances to do something I hate to do, which is be a little brutal and sometimes even rude, but I just ask you to bear with me as we try to march through it.

So we'll begin with Zoe Ann Murray, for the AARP. She will be followed by Joseph Cislowski, of the Center for Healthcare Rights.

MS. MURRAY: Good afternoon. My name is Zoe Ann Murray, a volunteer. And I chair the Health Subcommittee of the American Association of Retired Persons, known as AARP, the California State Legislative

Committee. Thank you for this opportunity to present some of the AARP views and concerns about managed care.

Given the large number of elderly persons, nearly 40 percent in California who receive health care through HMO's and other forms of managed care, the work of this task force is very important to AARP, representing some 2.8 million in this state.

Before I get into the meat of my comments, I definitely agree with you that the ongoing work of this task force must not be used by Governor Wilson as a reason for vetoing the managed care bills that are currently before the legislature. From my perspective the increased attention and scrutiny that is directed to managed care is appropriate and justified.

Although there's much potential for good in the clinical management of care, many of our constituents are concerned that their care is not being well coordinated but, rather, is being risk-managed by actuaries and consultants who set hard and fast rules without any knowledge of a particular patient's clinical circumstances. The ability of physicians to represent and advocate to the best interests of their patients is hampered by these rules.

Opinion polls show that the public strongly believes the government has an obligation to protect the quality of health care and provide information and quality to consumers.

Managed care has become the dominant delivery

system in California. While the inherent incentives of managed care create potential for high-quality cost-effective care, the same incentives, if abused, could result in the withholding or delay of necessary care. Consumers need protection to counterbalance the incentives to restrict care created by the payment system.

AARP advocates for managed care consumer protection standards in ten areas. These are enumerated in my written statement to you, and I will not take the time reading the list.

I would like to offer additional specific comments on a few of these areas. Regarding the appeals process in managed care, we urge the task force to consider the present Medicare HMO appeal process. This process requires review of disputes over medical necessity by an outside entity having medical expertise which has no ties with the HMO. This should be a model for private sector managed care. This process is not perfect such -- as such. But it is better than the current structure of managed care internal appeals process and present services available through DOC.

Regarding financial incentives, HMO's and managed care plans have developed a myriad of payment mechanisms that place physicians at financial risk in order to achieve the cost-conscious behaviors that saves money. Financial incentives that foster the delivery of high-quality cost-effective care are encouraged. Those that create barriers to care or lead to under-services

should be prohibited. Health plans should be required to make information about the financial arrangements with their providers publicly available.

DR. ENTHOVEN: Would you please summarize the rest in the interest of the people that follow you.

MS. MURRAY: Yes. We believe that issues such as safe discharge from outpatient surgery, access to a second opinion, response times in managed care plans, and disclosures of criteria for authorizing or denying care are fundamental provisions that should be incorporated into the day-to-day operations of any managed care plan operating in California.

AARP is willing to share with the task force resource materials that may be useful to you and hope members of staff will contact us for additional information.

Thank you very much. And I have from Dr. Beatrice Braun, M.D., a limited number of copies of her testimony to the U.S. House of Representative Ways and Means Health Subcommittee on this.

DR. ENTHOVEN: Thank you very much.

Next is Joseph Cislowski, and then Vincent Miller will be on deck, please.

MR. CISLOWSKI: Thank you, chairman.

My name is Joe Cislowski. I'm executive director of the Center for Health Care Rights. The center is a California-based, independent, non-profit organization dedicated to protecting and furthering the

rights of health care consumers, particularly with respect to MediCare and managed care issues. We are dedicated to insuring consumer access of quality health care through information, education, counseling, advocacy, and research programs.

We help elderly and disabled consumers to use their MediCare benefits effectively, make informed health care choices, take appropriate actions to resolve individual health care coverage problems.

The center offers Los Angeles County's Medicare beneficiaries with the following types of support: First, every year more than 5,000 Los Angeles County Medicare beneficiaries and their family members contact us for our counseling services. Our staff and volunteer counselors respond to a wide range of concerns, Questions about Medicare eligibility and benefits, cases in which patients have been denied access to necessary medical services.

Second, at a time when the Medicare program is undergoing so significant a restructuring, there is so much uncertain about the impact of reform. And the center serves the vital source of consumer information. We reached over 10,000 people in L.A. County this year through our community-based workshops.

Finally, in more complex cases, such as Medicare claims and complaints about Medicare or the health care practices, the center provides legal counsel and representation.

Informed on a daily basis by the critical issues confronting our clients, we respond to U.S. policy makers on views of consumer-oriented health care issues. We also engage in systemic advocacy through such programs as our health rights hotline program in Sacramento -- we also conduct quality research and public studies on issues such as managed health care and our most recent publication -- throughout the United States.

All this work, we have found that dramatic demographic shifts and volatile health policy environments are jeopardizing the safety net for health care consumers. Among the issues affecting the elderly constituency of our center are the following: The dramatic rise of Los Angeles County's elderly population, increasing ratio and ethnic diversity among the elderly, and corresponding -- for health care among the elderly. And as you know very well, the rapid growth of managed care plan in Southern California. And also pressures to reduce managed care spending for the elderly and the disabled.

As a result, the volume of calls from Medicare beneficiaries to the center's hotline has increased tremendously. The problems our clients are facing have grown more complex, requiring additional time investigating and resolved, thereby limiting the number of cases.

DR. ENTHOVEN: Please summarize.

MR. CISLOWSKI: To cut to the recommendation -- and I'll be glad to share the

information with you individually -- we hope this task force will continue, as it proceeds with its mission, to review or make recommendations. We hope that you'll keep in mind the importance of programs such as the health insurance counseling advocacy program that exists throughout the state of California, and experiments such as our hotline in Sacramento. These programs improve access to health care by empowering health care consumers to use their health benefits effectively and make informed health care choices and take appropriate action to resolve the health care coverage problems.

DR. ENTHOVEN: Thank you very much.

MR. CISLOWSKI: Thank you.

DR. ENTHOVEN: I'd like to request, if you have a statement, I promise I'll read them on the plane tonight. I think you'll be much more effective if you could get to what are the -- really the points that you want us to take home, the highlights, if you like.

Next is Mr. Vincent Miller, of the Berkeley Economic Research Associates, and then Dr. Stuart Cohen will be on deck.

MR. MILLER: Thank you, Chairman Enthoven and members of the task force. I timed my comments to take exactly five minutes. I'll try and talk fast and clear, and I will give you a written version in case you miss anything.

My name is Vincent Miller. I'm a managed care economist and the president of Berkeley Economic

Research Associates. I've worked in health care for over 20 years. Before starting there, I was Deputy Director of Research at AAHP, in Washington. I worked for Kaiser Permanente for several years. I hold a Ph.D. in economics from U.C. Berkeley and an MBA in epidemiology from Columbia University.

I submit that the solution to the problems with managed care in California lies entirely in empowering the patient that lies with institutionalizing the idea of consumer sovereignty. This idea may seem obvious, but it is certainly far from the reality in California. The players with the power in health care are, in decreasing order, the plans, the big payers, and the providers, followed by the patients.

I offer more detail in terms of three specific issues. The first has to do with the financial structure of the industry. The second is about provider incentives. And the third concerns the search for adequate methods for risk assessment and risk adjustment.

I illustrate the financial structure with my first diagram, which you should all have a copy of. There's two diagrams stapled together. In the middle are the patients, the actual consumers of health care. Surrounding the consumers are the three other kinds of players in the industry. The providers, the plans, and the employer payers. Solid arrows represent funds flowing between the kinds of players. Hollow arrows represent flows of services.

Consumers are caught in a tangled web. The picture is too complicated. There are too many arrows. The ones that disempower consumers and thus the best candidates for elimination are those from the employer payers to the plans and to the providers.

To empower consumers, we must minimize the financial intermediary role of employers and governments. Government's only essential role is as a rule setter and a resolver of disputes. Business's only essential role is that of the efficiency consultant. The arrow from patients to providers can also be practically eliminated. This would yield my second simpler diagram, which you also all have.

An interesting idea to see in this diagram is that once the employer payroll is minimized, the decision between a health plan and a consumer-run purchasing cooperative becomes blurry. The second issue has to do with the conundrum of provider incentives.

Under the old fee-for-service indemnity insurance system, providers didn't have an incentive to keep costs down or even keep people well. The best yield for doctors was well-insured chronically sick patients for whom lots of tests and procedures are justified.

Under the new managed care system, doctors have an incentive to keep their patients well. But when the patient gets very sick or chronically sick, the best thing for doctors is for the patient to just disappear. Neither the old nor the new incentives are right.

We want doctors to try and keep patients as healthy as possible and to aggressively but efficiently treat medical problems when they arise. All other things constant, the healthier a person is, the bigger the reward the doctor should get. Or when persons get sick, the faster and more completely and efficiently their doctors make them better, the bigger their reward should be.

Describing how to implement such an incentive system takes more time than I have here today, but it's not impossible. I will ask you for an additional minute to treat my third issue --

DR. ENTHOVEN: I'm sorry --

MR. MILLER: -- risk assessment and risk adjustment, of which I'm something of an expert. And I think --

DR. ENTHOVEN: I think the task force -- tell us what you know in one minute.

MR. KERR: Tell us what you know in one minute.

MR. MILLER: I will give you my comments. I will not tell you what I know, which seems to be the Holy Graile of managed care. If it's done right, incentive problems will supposedly dissolve. Providers would be rewarded for taking on the toughest medical cases and handling them effectively. The problem seems that nobody's figured out how to do them right. Available techniques require too much data, or they penalize

providers, serving high cost patient pools or both. So we await a technical fix.

As a mathematical health care technocrat, I ought to see it this way, but I don't. The problem is institution, not technical. Any representative panel, such as this task force, along with actuary or two, could do the job. All it needs is the authority. Given that, there are just two questions it must answer.

First, how are the categories of patients' conditions or events defined for which provider payment rates are to be set? And, second, what are the rates for each of those categories that make providers financially indifferent over the kinds of patients' conditions and events that they treat? It's not hard. It's not obscure. It doesn't require years of research.

The real problem is one of authority. And the solution to the problem of authority lies back in my first issue, consumer empowerment through a simplified financial organization of health care.

Thank you very much for your time.

DR. ENTHOVEN: Our next speaker is Dr. Stuart Cohen.

Dr. Cohen, I'm not going to be able to be as generous unless you have another friend on the task force.

MS. SEVERONI: I just wanted to reconfirm my support for keeping a fair and open process here. And that means that you set a standard, and we just have to

stick with it. So I ask your colleagues --

MR. LEE: Now that you're talking about all the ground rules, I feel nervous not being able to call -- I'd like us to on occasion -- not just to stretch out one speaker, but to be able to follow up. And so that -- I agree with you, but how can the standard be that anyone could have actually been able to do that briefly --

DR. ENTHOVEN: Well, we're going to be here all night, Peter.

DR. COHEN: Thank you, Mr. Chairman. I'm a private-practicing pediatrician in San Diego. I'm the president of the American Academy of Pediatrics Chapter, San Diego and Imperial counties. And I also sit on the statewide board of the American Academy of Pediatrics, representing over 5,000 pediatricians in California. I've condensed my remarks, and I have three statements I'd like to make and then a summary.

First, about vaccines and the public health role the pediatricians play. Private provider pediatricians in San Diego County provide over 80 percent of the immunizations in San Diego County. Public sector provided 20 percent. Rapidly expanding vaccine research has given us a number of vaccines in the pipeline, including nasal spray, flu vaccine, and RSD virus vaccine.

Many of the managed care contracts typically are negotiated every 12 -- 24 months and do not provide for reimbursement for newly established vaccines that may be improved by the AAP. Therefore, there are financial

disincentives for the medical --

DR. ENTHOVEN: -- just have to give us the headlines and try not to read your whole statement --

DR. COHEN: I think it -- my statement here says that we would like to make sure that vaccines are carved out of any capitated payments and paid separately for the provider, and also for the administration of the vaccine so that the providers of California should not be forced by the managed care groups to carry the financial burdens of technological advances on their backs.

Number two, HEDIS -- new and improved HEDIS -- one major criteria for measuring quality in pediatric practices. And that's the immunization compliance rate at age two. There must be other measurements that we can come up with to properly assess physician quality.

American Academy of Pediatrics physician research is willing to work with you, the task force, and with managed care groups in establishing better outcomes. Along this line, we'd like to wean off managed care groups from doing multiple side lines.

I have four physicians in my group. We have ten managed care plans. We have 40 cite items per year. We would like a universally accepted audit done once a year per provider that could be universally accepted by all managed care groups. This is very instructive at the present time for patient care.

Finally, pediatric subspecialists. We ask

that you take into consideration the fact that all managed care plans shall appropriate a reasonable access by referral to pediatric subspecialists. This is referred to as "volume outcome relationships," and we know this well. For example, pediatric cardiologist sees a much greater number of patients than an adult cardiologist and eventually has greater efficiency and better outcomes than the pediatric cardiologist.

In closing, I'd like to say this. Kids are relatively inexpensive and cost-efficient to cover. And, therefore, a small percentage of Medicare managed care organizations revenues come from children. These are called "externalities." In this case providing quality comprehensive coverage for kids benefit society by investing in the health of children. The benefits don't just accrue to the individual plan providing the coverage or the family employer making the purchase.

There is thus an appropriate and necessary role for government to support children and through government oversight and audit consolidation and through further development of outcome research.

We, the AAP, in closing, say we would be happy to serve as a resource to your task force, improving manages care outcomes in the state of California.

Thank you.

DR. ENTHOVEN: Thank you very much, Dr. Cohen.

Our next speaker is Jamie Court, with

Terry Johnson on deck.

Mr. Court, I hope we won't spend a lot of time revisiting the issues that we spent an hour or so on this morning --

MR. COURT: No. I just want to thank the task force for making a statement that says that a legislation audit should be judged on its merit. Since I'm here in L.A. and I'm going to submit some written testimony and outline some broad headline areas that I think we need to come to some conclusions about issue-wise. I have some recommendations.

The first is capitation. And the way I see it, the fixed budget pays doctors for all a patient's needs, regardless of how much care they need in advance. This fixed budget, this capitated rate, has some real incentives to pit the patient and the doctor against each other and their interest against each other.

And I think this task force would be real remiss if it didn't make a statement about capitation -- at the very least, a disclosure statement about whether capitated rates should be disclosed. We know that doctors are paid per head in advance a capitated rate in the single digits for some patients. That is a hard thing to swallow, but it happens today.

So I ask you to address a couple of areas, capitation being one of them in your final report. The other area -- and I think it's a little easier to address these days -- is the issue of your accreditation in health

care.

We see medical directors who intervene in the doctor-patient relationship, who are not examining patients, who are making medical decisions. That is something that we feel is wrong. We think that -- and there's a bill in Sacramento that says if a doctor examines the patient, recommends care, and that patient is seriously ill, the only way the HMO should be able to deny that care is if you got a physical exam by another equally qualified doctors. It makes sense. It particularly makes sense when you consider the degree to which doctors are capitated today. There is already an incentive against, quote, frivolous medicine. So I think bureaucratization is the second area.

Third area is liability, an area that I'm not certain that this committee will want to take on. But I think it's one you have to. Because, federally, people are preempted from getting many of their state consumer remedies by a law called the ERISA, Employment Retirement Income Security Act. ERISA is a bar's state court action for certain types of damages. So there's really no incentive.

Harry Christie is sitting here. He can tell you about it because in his case he had a daughter who had a cancer, and she needed some treatment from a specialist. So he when he went to arbitration against the HMO's, all he could get from that HMO, because ERISA was not punitive, damages. It was the cost of the treatment

denied in the first place. The guy couldn't even get his legal fees.

So there's really no incentive in terms of HMO accountability. And I think there are two ways to address them. One is a recommendation to the federal government about changing ERISA preemption. The second is recommending in any way you can so modification like a Texas law that was recently enacted which allows for certain professional negligence actions, which aren't exempted from ERISA like bad faith actions are in a state court. So there are remedies for a consumer, and that is a broad, non-body part legislation recommendation.

The last area is consolidation and mergers. And I think when you have three HMO's in the state covering 10 million of the 14 million Californians and HMO's without much scrutiny at all, you need to deal with this issue and say what you believe the effects of this rapidly consolidating industry is, how it affects the patient, what kind of safeguards we need to protect from a few HMO's really forcing the capitated rates so low for docs that they can't survive on a reasonable budget.

Appreciate your time. And I will have more formal comments for the committee as time proceeds.

Thank you.

DR. ENTHOVEN: Next is Terry Johnson, with Dr. Vince Riccardi on deck.

MS. JOHNSON: Hi. I'm Terry Johnson. This is my husband, Jay. We're here to address the committee

and to ask you to please take this seriously. We're here because of the unfairness and injustice we received from our HMO and then by the way the Department of Corporation handled it.

We lost our daughter Melody on December 12, 1995, due to the quality of services provided by our HMO and medical group. Our daughter was not even given the medical standard of care for cystic fibrosis.

We, as consumers, have been led to believe that a section of the Department of Corporation is set up for the public's protection when a problem with an HMO arises. We were led to believe all a consumer needs to do is file a formal complaint with DOC and that a full investigation will be done on their half. This is not true.

Let me share a story with you. We filed a formal complaint with DOC in November of 1996. It took four months to receive an answer from them. They stated that they did do a full investigation and felt that our HMO did not violate the Knox-Keene Act and then closed our file.

HMO merely gave the appearance that it had not violated the Knox-Keene act. But our concern is how could a full investigation have taken place when the Department of Corporation never once contacted us during the so-called investigation? We were the ones that filed the complaint.

We would like to ask why they did not want to

review and discuss any of the information we had compiled detailing our experience with the health plan on our daughter's behalf.

We have seen firsthand that the playing field is stacked against us, the public, and we have some information to support this experience. We would like to submit some of this information to the task force and following attachments to go along with our testimony. And where do we go now when the Department of Corporation falls short on their responsibilities?

Our name and address is in here, if any one of you would like to contact us further.

DR. ENTHOVEN: Ms. Johnson, thank you very much for the statement. I promise you I will carefully read the whole thing, and I expect that --

MS. JOHNSON: Could I ask that --

DR. ENTHOVEN: -- Department of Corporation --

MR. LEE: I'd ask that copies be circulated throughout the task force.

DR. ENTHOVEN: Next is Dr. Vince Riccardi, American Medical Consumers.

DR. RICCARDI: I'm Vince Riccardi, president of the American Medical Consumers of California, for-profit corporation. It is on the basis of handling over 1,000 -- almost 1,000 medical consumer inquiries over the last two years, giving me a reason why I just want to make a couple of statements here.

I first will make several comments, make three recommendations and, if the time allows, give you two challenges. It is very important that through such things as the Internet that doctors and those for whom they represent as agents no longer have a monopoly on the information that is required for cogent medical decision making. That information is now very much available to the average consumer.

My second comment is that we have to start considering the individual as a medical consumer, not as an alternative phrase to patient, but as an additional aspect of what it is to be an American. They are both consumers, and at times they're also patients. We must take into account consumer protection in terms of what -- how we do for all other industries. We have to return to a focus on value and process. And value, not from the dollar's standpoint, but value as determined and voiced by the medical consumer.

It's very important to understand that the horror stories that we see in the public media, which are sometimes discounted as yellow journalism, plain and simply are not that. When I hear the calls that come into to me day after day by people who have not gone to the media that just have the same kinds of problem, only they just aren't going to go to the media. Those problems are there. And we have to pay attention to them.

In terms of recommendations, among the ways we could have improvement in what goes on really empowers

the consumer? Make arrangements so that for all the managed care group committees have patients, medical consumers, on committees, including utilization review committees, credentialing committees.

My second recommendation is to ask the task force to consider that a personal medical record -- medical records kept by and commensurate with the medical education of medical consumers should be seen as equally cogent to the provider-based medical record and that that personal medical record be sought out to be part of the medical record.

And a third specific area of recommendation is with regard to the phrase "non-compliance." Non-compliance is often used as a defense by a physician for why the outcome wasn't good. At times the term non-compliance is used as a behavior description. At times it is used as an allegation. And at times it is being used as a diagnosis.

I ask the task force to take into account, including with the discussions with emphasis, with more reasonable utilization of that term as it relates to the delivery of health care.

Thank you very much.

DR. ENTHOVEN: Thank you very much, Dr. Riccardi.

Next will be Mr. Don Gaines. Is there a Don Gaines here?

The next speaker will be Dr. Paul Bronston,

national chairman of the ethics committee, American College of Medical Quality. Dr. Bronston?

Ms. Laura Remson Mitchell, National Multiple Sclerosis -- are you Dr. Bronston?

DR. BRONSTON: Yes, I am.

I'd like to thank the task force for giving me an opportunity to make a brief statement. I'm Dr. Paul Bronston. I'm national chairman of the ethics committee for the American College of Medical Quality, and I'm a practicing emergency medicine physician here in Los Angeles, California.

I've had -- over the years my involvement in health care delivery has been how we can set up systems that are not dysfunctional like our present system is in order so we can delivery quality medical care, delivered in an efficient and cost-effective manner.

I'm on California's Medical Board. I've consulted with the division of Workers' Compensation. I'm one of the experts for the Department of Corporation, and I'm also a consultant for the Probe for California.

I can tell you also, by having over a decade of experience consulting as a physician advisor for numerous utilization review organizations, I certainly understand from all parties' perspectives what their concerns are. And I can tell you from my past experience I have never seen a more dysfunctional system in my entire life.

You have -- this is a feeding frenzy that's

going on in this country right now in which you have some elements of the payers, some elements of the providers, and even some patients that are trying to rip off the system.

And these type of systemic problems have to be addressed. I can tell you that system problems are more dangerous than individual errors, individual physician problems.

My expertise is analyzing and understanding how systems work and how they interact in the health care system with the patients, the providers, and the payers. I can also tell you that I am for managed care.

I support managed care. I support managed care systems. But I can also tell you that there are a certain percentage of managed care systems that are frauds, that are nothing but managed cost systems that are market-driven.

Now, it's very important -- I don't particularly care what the recommendation of this task force is where the new type of regulatory body should be. If it's the Department of Corporations, whether it's in the medical board -- it doesn't matter.

What matters is is that whatever regulatory body that you should invest the power in and that you recommend where the power should be held, that they, number one, have the expertise to evaluate these systems. And they have to be medically controlled. Because you cannot have non-physicians understanding and looking at

these medical systems to see whether or not they're dysfunctional or not.

Number two, you have to have them staffed well enough so you can investigate the managed care systems to be able to see which ones are doing it right, so they can be encouraged and educated to propagate, versus the defective and the corrupt ones, which you need to get rid of.

Thirdly, they have to have enforcement capabilities. While you have an organization on a regulatory body that needs to be able to do this, there is certain fundamental principles that have to be adhered to. Three principles. And I would just like to emphasize they need to be adhered to, no matter what regulatory body decides to take this huge project on.

Number one, financial incentives that corrupt medical decision making, whether it's a fee-for-service system that causes physicians to overutilize rewards or capitation agreements that causes physicians to underutilize the rewards financially.

Number two, protecting the physician-patient relationship and eliminating the gag clauses. The physician-patient relationship is sacrosanct. It is absolutely important. It's just as important as a husband and wife relationship or a relationship between a person and their priest.

Number three, you -- there are many defective credentialing systems that are out there now that report

card and profile physicians and even HMO's and even hospitals defectively and give them bad report cards and do not evaluate them appropriately.

These are the principles that I think that any regulatory body has to address and have to make sure that they're adhered to.

DR. ENTHOVEN: Thank you very much, Dr. Bronston.

Next speaker will be Laura Remson Mitchell, with Patti Strong on deck.

MS. MITCHELL: Good afternoon. My name is Laura Remson Mitchell. I'm a public policy analyst, consultant, and writer, specializing in economic disability in health care issues.

In addition to working as a general public policy analyst and consultant on these issues, I'm also the government issues coordinator for the Multiple Sclerosis California Action Network, a coalition of the California chapters of the National Multiple Sclerosis Society.

First, I want to make it clear to the task force that people with disabilities and serious chronic illnesses aren't some kind of special interest group. We're, in effect, the canaries of the health care system. When something goes wrong with the system, we're usually the first ones to suffer, but we aren't the last. And I think a lot of stories you've been hearing from some of the other people giving testimony are things that people

with disabilities have been experiencing for a long -- for a long time.

Generally speaking, the problems faced by people with disabilities in managed care plans fall into two general categories. Access and benefits design. But overlying the whole thing is that that basic insensitivity, widespread insensitivity, and unawareness about what living with a disability is really like, a complete misunderstanding of reality. It's widely acknowledged that managed health care plans like straight indemnity insurers try to avoid high risks. We all know that that goes on. But many managed care plans have honed this to a fine art when they can't reject people out of hand outright.

Plans can and do manipulate the benefit packages and their contract providers -- contract provider list. They can and do limit access to information about specialty providers and about treatments to the extent the law allows -- I realize there's some changes limiting that -- and they can and do discourage people with high-risk disabilities and chronic illnesses from enrolling.

And sometimes they get very creative in the way they do that. For example, marketing materials may be provided -- may not be provided in alternative formats for people who are vision-impaired. The meetings, marketing meetings, may be held in inaccessible locations as a way to keep out people with mobility impairments. And

customer service lines of these plans often don't make allowances for people who have hearing impairments when they need to use TDD systems or relay options operators in order to communicate.

That's not only important to the marketing phase. It's extremely important in the phase of somebody really actually who must get into the plan.

Once a person with a disability is enrolled in a managed care plan, that doesn't end the problems. There are physical barriers, communication barriers, and problems with access to specialty providers who really don't understand what the disability is like. There are many, many problems that have involved incorrect treatments, inappropriate treatments, because the provider did not really understand the nature of the disability involved.

But perhaps the biggest problem for people with disabilities may be the fluid definition of the term "medically necessary." Not only is the definition hard to pin down, but it's usually characterized by acute care bias that's focused on cure instead of on maximizing functional capability.

I see Dr. Enthoven kind of chomping at the bit. I'll try to rush --

DR. ENTHOVEN: But I'm thinking this is a major problem in the development of education of doctors. Their training is acute-care oriented, almost to a fault sometimes.

MS. MITCHELL: Absolutely. The interesting thinking is that managed care isn't done in what I consider the right way -- could be a very good bridge to correcting that imbalance. But the way things are right now, with decisions being driven primarily by short-term process considerations, that isn't happening.

Problems that people with disabilities are dealing with in managed care are partly related to the lack of understanding about disability itself, but also they're systemic as relates to the economic incentives and the fact that the market will actually punish plans and try to treat people with disabilities in an appropriate way because they want to draw into higher risks.

So that draws me to one very important point I want to make. I understand that the task force is very much aware of the need to improve choice and information available to consumers so that consumers can make informed choices.

But unless something is done to level the playing field between health plans so that the risks are spread evenly, that's not going to work very well for consumers. That's going to wind up actually hurting many of those who are high-risk. And in the words of what I've been egotistically calling "Mitchell's Corollary," in the absence of a level playing field, the bad plans are driving the good plans out of business. I think that that's a very important area for the task force to work on.

I've submitted some material to the task force that will elaborate further on some of these points, and I'd be happy to work with you in any way I can. But for right now, the point I want to make is that managed care cannot be permitted to continue ignoring the needs of people with disabilities and chronic illnesses.

I hope members of the task force will incorporate that into your thinking, into your report, and into your recommendations to the governor.

DR. ENTHOVEN: Thank you very much, Ms. Mitchell. I think we do understand it's important, the idea of leveling the playing field.

Our next speaker is Patti Strong, followed by Jeannie Brewer.

MS. STRONG: I feel particularly fortunate to follow the last speaker because many of my remarks are relate to hers. I come to you as a person with a disability. In fact, I come to you as a person aging with disability. And I want to make a contrast between aging into disability, which most people do, and aging with disability.

I come to you also as a professional who, over the last ten years, has done service delivery for people with disabilities, primarily people like myself, with mobility impairments. So I don't come with a particular ax to grind or a story to tell of my own, but I've heard hundreds of stories over the years, many of them sad stories, having to do with managed care.

I come to you also as a person interested in disability studies. I was a collaborator on research projects on aging with disabilities, a biopsycho social model.

I have essentially four points I want to state today. One is the people or persons with disabilities are a vulnerable population. But we often occupy several vulnerabilities. 68 percent of people with disabilities do not have full-time employment. More people are disabled who are non-white and who are women. So you can see that a person with a disability very often occupies several vulnerable positions.

I also want to acquaint you with the idea that disability is not a static condition. I am aging with a disability. And what I really was struck by in our last presenter was the idea that acute care is the model for the medical profession, and we need much more a long-term, a cross-generational or cross-aging model.

And I want to show you some equipment that I've had over the last ten years. You see, I had polio at age 2. And for about 30 years, what I thought was that it would only affect my right arm. My right arm is paralyzed. It always has been. I wear a lot of equipment these days, but I wear it primarily for the sake of my left arm, which I used to think was unaffected by polio. That's not true. Those of us who are aging with disability understand now that disability is not static, that it changes over time.

So because I'm losing my thumb, I now wear a very attractive pink, bubble gum pink, hand brace that keeps my thumb in position. The very first one that was made for me was made by an occupational therapist. It lasted for a while. But my thumb got worse. I needed more intervention. I went to this one. Then I went to this one. Now I need the super industrial-strength model. This one is made from the same plastic that makes your battery case for your car.

And so what I want to say is that people with disabilities need re-rehabilitation in order to maintain the functional status and independence that our last speaker addressed. I'm going to need many more interventions as I age, many more than you will.

And what I want to convey to you is that disability is not static, that many of us nowadays are aging with disability. There are 5 to 10 million people in this country who have early onset disabilities. And we are reluctant pioneers. You are all on the cutting edge.

This is the first generation with a large cohort of people aging with disability -- aging with Cerebral Palsy, aging with polio, aging with strokes, spinal cord injuries, rheumatoid arthritis -- who are coming. Are you ready? Are you going to put us into your plan?

When you think about managed care and how to deregulate it and the policies and all of the issues, do

you know that we're coming and we're going to have ongoing needs and that capitation for us really doesn't work in the same way that it works for those aging into disability? Please remember us.

DR. ENTHOVEN: Thank you very much.

Dr. Jeannie Brewer from DADA.

DR. BREWER: Good afternoon. Thank you. I'm Dr. Brewer. I'm a physician and on the faculty at USC. I've been in private practice here in L.A. in the past. I'm also a member of the California Physicians Alliance, which is has been after national health care reform for many years.

I will shorten my statement as I know there's a physician following me to talk about terminations of physicians without cause. I think it's a very important issue. However, I will talk today about the role of medical groups and medical director liability.

Medical groups, as you know, have shifted dramatically. Their role has changed. Large medical groups are often now functioning as managed care organizations, and they're accepting substantial amounts of risk through a wide variety of financial arrangements. And they attempt to control cost and market shares.

So medical groups are in some ways functioning like HMO's. But as far as I know, they are unrelated entities. And I don't know who regulates them. The medical board licenses individual physicians, not medical groups. The Department of Corporations licenses

HMO's, not medical groups. So that's something you should consider when you're talking about managed care.

Secondly, medical director liabilities, which also includes not just the director but any partners, medical service organizations -- anybody who is a decision maker at HMO's -- it puts the physicians in a very, very bad position when things are denied, medicine is being practiced, but you don't have the decision making capacity.

Many of these directors are doctors who are on the phone, making decisions that directly affect patients that we are seeing in person. I know this was being addressed earlier about the physical exam. I want to reiterate the importance of that.

This is the standard of care in the United States. A patient is examined. A patient is spoken to. Not someone on the phone makes a decision about that patient's care. I know this is a complex issue, but it really is at the heart of the doctor-patient relationship and about patient care accountability.

And a lot of life-threatening decisions are being made at a distance and at the distance of the phone line, at the distance of non-accountability, and the distance of financial gain. These are all things that need to be seriously considered. Not only because it's an issue of basic fairness for patients and physicians alike, but accountability, which is the most important thing.

Those at the other end of that phone line

might just be forced to make the right decision in this way despite the conflict that they're in. And earlier the medical board talked about explaining doctors --

(Whereupon a rat disrupts the proceedings.)

DR. BREWER: Oh, my God. I'm being haunted by my previous research experiment.

(Whereupon a break was taken.)

DR. ENTHOVEN: Dr. Brewer, would you please continue as if nothing happened.

DR. BREWER: I only had about one sentence left, but I was on a roll. I lost my rhythm, but I will try.

I was just talking about -- before the rat disturbance, I was talking about medical director liability and partners in medical service organizations. And they had to be held accountable because the fairness issue for physicians and patients but also because of the accountability issue. And I just wanted to say that earlier the representatives from the Medical Board were here, and the conversation came up about protecting the public and protecting patients.

And, clearly, disciplining doctors and removing licenses or doing whatever needs to be done is part of their role. And what I'm saying is that it can certainly make sense to do that with anybody who is making medical decisions, including medical directors. So I just wanted you to consider that issue.

I seem to be the first person who made it

before the bell? And with rat.

DR. ENTHOVEN: We gave you a special dispensation for the rat.

Okay. Maxine Stewart?

DR. JENSEN: Oh. I'm Claudia Jensen.

DR. ENTHOVEN: Okay. Dr. Jensen.

DR. JENSEN: I'm a pediatrician from Ventura County. And I have spent the last 12 of the last 13 years in managed care as a staff-model HMO physician. What that means is that I was an employee of a managed care medical group. As an employee, I did not own the business. I had no significant vested interest in the business, but I did have some significant incentives to keep from providing my patients with the best medical care.

And this was manifest to me when I identified some quality of care issues that I brought to the attention of my supervising physicians and our medical director and our quality of improvement director. I told them about some problems we were having.

I sat on the CQI committee, the Continuous Quality Improvement committee. I was a committee member and have always have been a very active proponent of patient quality of care. I brought some specific issues to my employers' attention. I asked them to address them. It created somewhat of a political furor. I wrote a letter. The letter was addressed to key people -- medical director, CEO, director of the CQI committee, et cetera. And at the next CQI committee, when that letter had still

not been addressed, I asked that the letter be put on the agenda for the next CQI committee meeting. And I was told "This is not a forum to discuss your letter, Dr. Jensen."

And I said "Well, I'm a member of the committee, and I am formally asking you to put this item on the agenda for the entire committee to discuss, not just one or two people." I was fired six days later.

Now, they allegedly told me it was a layoff. They were down sizing. They did not have any money. They hired another pediatrician. She started work five weeks later to replace me. Credentialing a physician takes significantly longer than five weeks. I think they started looking to get rid of me as soon as I started making noise.

In fact, we are involved in litigation. They are spending tons and tons of dollars defending this case. And I am impoverished. I have no health care for my children. I haven't made my last two car payments. And I'm here to tell you that what the managed care medical group does to the physician in the state of California is strongly encourage them to keep their mouths shut. Because if they speak up, they're in danger of losing their abilities to feed their children.

The "for clause without clause" contract needs to be obliterated. Every physician that works for a managed care corporation in this state has an opportunity to get terminated without cause.

Is that three minutes?

DR. ENTHOVEN: Yes.

DR. JENSEN: Oh. Okay. I think that's a big issue. Physicians need to not be afraid to advocate for their patients, and it certainly should not impact on their ability to provide them -- their families with care.

The other thing that I think is important, to give the medical group some liability and accountability for the decisions they make. I think it's important to make the medical directors, the MSO committees, and the partner, the people who make the decisions, they should be responsible for their decisions in some way.

The other thing is I think the financial incentive that corrupts physician decision making should be specifically addressed. And I believe that there should be patient advocacy units so that the patient could be included in the utilization review process. I'm tired of people sitting around, talking about patients behind their backs. The patients need an opportunity to know why decisions are being made about them, and they should have an impact on it.

I also think that -- the last thing is marketing. What the patients are told and what they are actually delivered are light years apart.

I would like to make myself available to any of you. If there's any way I can help you in anything that you're doing -- I'm a former believer of managed care. I would like to try, if there's some way I can help

you. There are things that need to be done. And I think it can be done. Empowerment is an issue. I'd like to help.

DR. ENTHOVEN: Dr. Gilbert.

DR. GILBERT: Dr. Jensen, thank you for coming and testifying. Two quick questions. You obviously had a horrible incentive of being fired if you acted out beyond the bounds of what they wanted. You were employed.

Were there other financial incentives in terms of issues about withholding care or not providing care? You mentioned "incentive," and I didn't know if you were only talking about a horrible incentive of being fired versus others.

Two, when you say "hold the medical group responsible," in this case it wasn't the HMO per se. It was the medical group that employed you.

DR. JENSEN: Right.

DR. GILBERT: How do you view that that happens?

DR. JENSEN: I think -- actually, that's where all the bad decisions of managed care are being made, at the level of the medical group. The HMO's are under some scrutiny now. The medical groups have free license.

And the financial incentives are "You're a partner in this organization. We've got this big pot of money here in the middle of the room. And whatever we

don't give to the patients, you get to take home." And I think that that kind of a model needs to be eliminated from the plan.

DR. ENTHOVEN: The next person is Maxine Stewart. She'll be followed by Dr. Robert Van Peck.

MS. STEWART: I'm Maxine Stewart. I'm a C-6,7 quadriplegic due to an auto accident. I'm also a registered nurse. I paid into my HMO for over 30 years. And when I broke my neck, I was refused an operation that I felt would have helped me through another doctor who was outside the HMO but previously had been contracted by the HMO. He had a different technique that my HMO did not use. The social worker that helped me who had worked for the HMO at the time to try to get me to get this surgery was fired because of help he had given me.

Needless to say, I didn't get the operation. And I was put into 60 days' rehab, which is the maximum rehab that they give you. And after that I was either sent home -- which, of course, I didn't have a home at the time. So they put me on Medi-Cal. And I had never been on Medi-Cal or welfare. I paid my bills. I've, like I said, been a registered nurse all my life, two or three jobs. And this was really a blow to my self-esteem.

However, I'm thankful to Medi-Cal because they did put me into a spinal care hospital. And due to their care, I was able to move my right hand. After 60 days of so-called therapy at my HMO, they didn't even know

how to work my arms so that I could get full use or whatever use back that I could get of my right hand. They didn't work on it.

When I asked them -- and if they could build up the muscles -- I mean I know enough about medicine to know that you need to work the muscles and you need to exercise them to get them to work. They refused. The therapists, they didn't have any idea how to work with quadriplegics. They were used to stroke victims. These are two totally different disabilities. You need to have someone who is knowledgeable about your illness to be working with you.

Unfortunately, even with my medical knowledge and all the help I have through a social worker who understood the situation, they still turned me down.

From the spinal cord injury hospital, I still had nowhere to go. They threw me into a convalescent hospital. Fortunately, the hospital did have some rehab, and I obtained some rehab again. However, when the case worker from my HMO became aware of this, she got a little upset, and she cut me off all therapy, including range of motion.

By the time I met Cy Cy Lambert and she was -- she had -- she is the head of RDL Store, a volunteer spinal cord organization. She's the one who helped get me out of the convalescent hospital into my own apartment. She couldn't help me any more than she could. But she came to visit me as often as she could in the

convalescent hospital, trying to get my arms and legs moving. My hands had finally lie turned inward, and they still are twisted since I didn't receive therapy for six weeks.

I did try on my own to go and get some exercise. I had gotten on one of the handicapped buses and went to the spinal cord hospital where I was originally treated to work out in the gym. And I was trying to do this three times a week. When they found out I was doing it, the case worker from my HMO told me that I wasn't allowed to do this because, according to Medicare guidelines, I was not allowed to leave the convalescent hospital except for doctors' appointments or for a lawyer's appointment to settle my affairs. So I had to sneak out to go just to get some exercise. I mean it was absolutely ridiculous.

But I don't understand why managed care is allowed to play God. You know, somebody really wants to get better, and they find a way. And this isn't costing them anything. I was the one who had to pay to go to the gym, and they refused to allow me to go there. In fact, they finally -- when they did find out I was going there, they decided not to get me out of bed so that I couldn't get out of bed to go.

In conclusion, all I can say is I hope you take a closer look at injuries that are difficult and different. And if you don't have the type of care that is needed or the expertise, please make it mandatory that

managed care at least obtain the experts to take care of people like me.

We can all become rehabilitated to a certain extent and, hopefully, go out and lead productive lives. Many of us who are quadriplegics drive our vans, and we go back to work.

Thank you.

DR. ENTHOVEN: Thank you very much.

I think one of the things we'll need to address is the typical coverage contract. Because the 60-day limit is not specific to managed care. It's something that's decided by the employers or the purchasing coalitions. For example, in CALPERS, the standard HMO coverage decided by the PERS board is 60 days' rehabilitation therapy. If the EPRS board said they wanted 360 days and were going to pay for it, I believe the managed care companies would have been delighted to provide it. That's something that is determined by the PERS.

MS. STEWART: In the past, insurances have given many, many more months, so to speak, of care for rehabilitation for spinal cord. And these people have really increased their potential.

I have a private patient contract. My first husband was a school teacher, and he got better benefits. And then, when he died, they wouldn't allow me to continue that. So they asked me to pay privately. My premium was more, and my benefits are less.

DR. ENTHOVEN: Thank you.

Our next speaker is Dr. Robert Beck, and then Dr. Norman Shrifter will be on deck.

Dr. Peck.

DR. PECK: Thank you, Dr. Enthoven. I'm a cardiologist in private practice and have been doing this work for a number of decades.

I come to you today to ask your task force here to help us to redress the terrible imbalance between those of us who are providers of health care independently in the traditional Medicare setting where the health care financing administration pays us directly rather than an intermediary area in the form of an HMO.

Parenthetically, the HMO's take out in this state an average of 20 percent of every dollar that the Medicare administration passes on to them and leaves 80 percent, a rough average, for lost ratio. "Lost ratio" means giving care -- what you pay to care for patients.

MediCare traditionally has been a 3 percent overhead operation and remains at that level. This is not a pure discussion that we're having here. It is not true, as has been stated by some, that ours is a cottage industry and that the cottage industry is over, and we are in the days of an industrial model of medical care. Both exist and coexist.

We don't believe that we can displace those of you who are in the health care business. We in the health care profession who are operating in the

traditional fashion just want a change to keep pushing our push cart. We may be the last push cart in this. We want to be able to do that.

Remember, please, that those things that are preeminent in American health care system were built by individual practitioners and small groups of practitioners. And the industrial model that's presented to us by the HMO's is quite the opposite of that. It's an untried path that you are taking us down. It has never been demonstrated to do the things that it claims to do. And I'm asking you that you take a new look at this problem, set aside prior prejudices or assumptions.

Example, there is no proven cost saving by HMO's for managed care industry in the whole system. Surely, they can reduce premiums to individual or groups of buyers. But the cost is, number one, that they cherry pick and they take the healthy providers.

There's an excellent article on this in the "New England Journal of Medicine" of July 17 in which they demonstrated that the people who enter the HMO segment of health care among the beneficiaries of Medicare are about twice as likely to be the healthy people and that those -- as the people who stay in the independent traditional Medicare setting.

And those people that leave the managed care arena go back to the private sector are much, much more likely, about 160 percent or 60 percent more likely to be the sickest people. And then when the level of sickness

drops off again, they're inclined to get back into managed care. So there is no proven cost savings.

What could there be cost savings in an industry which permits the man who sold USA Health Care to Aetna to take out $980 million from that transaction or permitted the Columbia Health Care chairman to run that organization in such a way that it's now under indictment for criminal behavior. And you have no controls over it.

There is a terrible discrepancy between the ability of us to be able to have some sort of management of anything that is so immensely powerful as billion dollar slush funds in a number of the HMO coffers --

DR. ENTHOVEN: Please summarize, Dr. Peck.

DR. PECK: -- what comes out of this is that we are now presenting a group of bills that are badly needed. And I'll cite only two of them. The first of these is the -- it would outlaw the right of HMO's to fire without cause. That's 434, AB-434.

And the second example is the inability -- not allowing the HMO's to deny care without stated reasons and second opinions, if demanded.

These bills are there. Now, it's very hard to hear you say this morning that you unanimously disavowed a rule of standing in the way of our bills the legislative process. It's extremely important for us. You have a chance to make a great contribution to the redistributing power in the health care system.

DR. ENTHOVEN: Thank you, Dr. Peck.

Last meeting we heard from Margaret Stanley, who runs the CALPERS system which buys care for a million people. And their premiums doubled from -- in the five years leading up to 1992. And from 1992 to now, they are down about 13 percent, 20 percent, if you account for general inflation.

So their experience as one large group in the state is called "Managed Care Entity." It has been -- it has reduced the cost. I think your statement is a little strong when you say there's no evidence of cost reduction.

AUDIENCE MEMBER: After doubling it and cutting down, I don't see the comment being at all improper. It should have been recited in stock. That's immensely unfair.

DR. ENTHOVEN: You're saying -- you're bringing --

AUDIENCE MEMBER: I'm saying the doubling in the first place should not have happened -- abuse of 13 percent --

DR. ENTHOVEN: -- the previous doubling was characteristic of the fee-for-service system. And the switch to managed care -- the purpose of it on the part of employers --

AUDIENCE MEMBER: I apologize, then --

DR. ENTHOVEN: Next is Norman Shrifter, M.D.

DR. SHRIFTER: Thank you for this opportunity for addressing the task force, especially for the

opportunity to renew old acquaintances with my friend Tony Rogers, who was my administrator when I was director of County Comprehensive Health Center a number of centuries ago.

I have two points I want to discuss, and I'll try to be as brief as possible. The first might be entitled "The God that Failed." I'm a recently retired internist after 46 years of practice. And I've always been involved with community. I served on the "Hope" ship in Peru. I'm actively involved in medical political circles. I've contributed much time to clinics, and I worked for Kaiser for 2 years.

And so when in 1985 we decided to form our own IPA, I was very pleased, and I was also very complimented that they chose me medical director. I believed in it. I believed in managed care. With the passage of time and the abuses of it and the fact that it was really denigrading to the physicians -- practically all of them were outstanding caring humanitarian physicians -- who am I to pass judgment on the validity of a certain procedure when I have never seen the patient? All I have is a list of things that are written on a sheet of paper. And the only physician who's taken care of a patient for 20, 30 years thinks that it's indicated.

I feel the processing denigrading, insulting, demeaning, and it's not good. At any rate, I wanted to speak against managed care on that basis.

The other thing, in line with the two

previous presenters, in 1994 I decided to join a foundation that was forming in our area of 40 physicians. And at that time I had been actively involved with the previous HMO or IPA. And when I announced to the director there that I was thinking of doing that, he said, "You know, you will be fired as a result." I said, "Why? I still have patients. I still can provide them care." He said "No. That would be a competitive situation."

I didn't believe that he would do something as unfeeling, as unthinking as that. But sure enough, after the 60 days' notice, I was fired and -- without any real cause. And I lost considerable amount of money. My wife and I both lost a lot of sleep. And I feel it was terribly unjust, and I hope that it never recurs in the future.

But I think there are a lot of important decisions that rest in your hands, and you have -- as my 11-year-old granddaughter would say, "You have an awesome responsibility."

Thank you.

DR. ENTHOVEN: Thank you very much.

Our next speaker is Dr. Paul Carlson, with Robert Park on deck.

DR. CARLSON: I'm the fellow who was hollering for "louder." Can I be heard?

MEMBERS: Yes.

DR. ENTHOVEN: Yes.

DR. CARLSON: Thank you, Professor Enthoven.

And I see that the other man I was to honor, Dr. Shumacher, is gone. I don't know why.

My name is Paul Carlson. I'm a graduate of the University of Southern California in medicine and served a residency in surgery in the Stanford University Hospital 1954 through '59 while it was still in San Francisco.

In partial answer to many references to earlier speakers to outcomes, evaluations, quote, unquote, I offer a reprint from the "Journal of the American Medical Association," volume 278, No, 2, July 9, 1997, pages 119 through 124, entitled, quote, "Outcomes of Stroke Patients in Medicare Fee For Service and Managed Care" with some of my own comments.

Authors were from the Medical College of Virginia, augmented by statistical analysis from the Mathematics Policy Research Institute of Princeton and used Rand, capital R-A-N-D, reference No. 14 in the article, "Medical Record Abstraction Form and Guidelines for Assessing Quality of Care" for hospitalized patients with cerebral vascular accidents. Hoping you will incorporate this in the minutes of this meeting.

The statistical analyses are exhaustive. And the abstracting was all done by nurses and is set to have taken one hour per case. I cite this because of the difficulty that the earlier speakers have given to the increasing of data.

The only amusing line in this survey's

conclusion is on page 121, column 2, paragraph 1, noting similar incidences of total morbidities, quote, "But fee-for-service patients had a significantly higher prevalence of a history of dementia." I don't know if that's -- has anything to do with their selection.

The conclusion of the article was "Patients in Medicare HMO's who experience strokes are more likely to be discharged to nursing homes and less likely to go to rehabilitation facilities following the acute event.

As one who would have been interested in stroke avoidance, I searched in vain for evidence of even meager efforts which can justify the capital M, maintenance part, of the title health maintenance organization. Such would include three things: no mention of any prevention of stroke strategy other than the general management of hypotension. That's cited in reference No. 6. No mention of highly focused search for the indicia -- for example, carotid arteries -- difference in simultaneously recorded left and right blood pressures and handedness of the patient, left or right. As you all know how much that decrees the outcome of stroke.

I think you're in for a hard job, and I think this leads to something that I, as a non-nephrotic person would like to bring to the Supreme Court. Why would nephrology patients have single-payer care? We all need it.

Thank you very much.

DR. ENTHOVEN: Thank you.

Mr. Park. Then we'll have Max Turchen on deck.

MR. PARK: I urge the members of the task force to support a guaranteed second opinion for members of HMO's. My mother would still be alive if there had been such a law a year ago. She passed away in April after being in intensive care for two weeks following a heart attack. Before the heart attack, my mother had suffered a number of angina attacks.

She told the HMO doctor of pains in her chest and arms. A year ago my father asked the doctor about her heart. "That's not the problem," the doctor replied.

After my mother had the heart attack, tests performed at the hospital showed so much heart damage that there was no chance to save her. The cardiologist said that, if the angina attacks were small heart attacks, each attack had damaged a portion of the heart.

Why didn't the HMO doctor recognize the warning signs of heart problem? Did the doctor have a blind spot? Had he exceeded his quota of referrals to a specialist? We will never know.

After my mother's death, my father examined her medical records. He discovered that an internist had recommended a stress test five years ago. The test was never performed. Was the test not performed in order to save money? We will never no.

We do know that doctors make mistakes. This HMO schedules patients ten minutes apart. It cost far

more for two weeks of intensive care for my mother than it would have cost to correct the problem, had it been detected earlier on.

Some might say that second opinions cost too much. But it is cheaper to correct a doctor's poor diagnosis with a visit to another doctor than to deal with the consequences in the emergency room.

I am an engineer for a defense contractor. I always have an another engineer review my work before I submit it. The earlier the defects are found, the cheaper it is to correct them. I also learn from other engineers' comments. Studies show that peer reviews of programmers' code decrease costs and increase quality. The government now requires defense contractors to conduct peer reviews as a condition for obtaining future contracts.

Second opinions are also valuable in medicine. It is dangerous for one HMO gatekeeper to control access to health care -- second opinions which improve the quality of health care, reduce costs, and save lives.

My mother can never be brought back. But because of her death, I'm doing whatever I can to bring about necessary reforms. If other people's lives can be saved as a result, then my mother will not have died in vain.

DR. ENTHOVEN: Thank you very much.

Next speaker, Mr. Max Turchen, and then Jennifer Palm, R.N., is on deck.

MR. TURCHEN: Mr. Chairman and members of the managed care and task force, I'm Max Turchen, chair of the Los Angeles Region of the Congress of Californian Seniors. We are one of the sponsors of the patients' Bill of Rights which consists of a comprehensive package of bills which addresses immediate needs and problems of health care consumers.

Hundreds of hours have been spent by legislators, legislative committees, and their staffs, proponents, and opponents of these bills which have passed, most often with bipartisan support. These bills deal with real problems, and their contents and recommendations should be considered in your final report.

One of your charges was to see that the system should deliver patient sensitive care. And that is addressed by the patient's Bill of Rights.

I have summary and fact sheets which I will furnish your committee. And I wish you well in your endeavors.

Thank you very much.

DR. ENTHOVEN: Thank you, Mr. Turchen.

Next speaker, Jennifer Palm, R.N.

MS. PALM: My name is Jennifer Palm. I'm a registered nurse. I'm currently the director of utilization and quality management in Blue Cross's Medi-Cal division. My message for the committee, basically, is that managed care, I think, is the way of the future. At least, I hope it is. I believe in managed

care. We do have problems with some of the systems. And I would ask the committee to, instead of deleting managed care, to look for systems, as Dr. Bronston said, to improve managed care and to allay some of the concerns that some of the people who have spoken today have.

What I'd like to do is give you a brief summary of how the utilization management at Blue Cross works. We have put systems in place to address some of the concerns that I've heard today.

First of all, we've divided our utilization management function into three separate areas so we could have nurses who specialize. There's a preauthorization function. There's a concurrent review function. And there is a case management function.

The preauthorization of services is done solely by registered nurses. These nurses follow very strict protocols which have been developed by associations such as the American College of Obstetrics and Gynecology, the American Academy of Pediatrics.

In no cases do nurses ever make denials. If the nurse has a concern about a procedure that's being requested, it's always referred to a physician.

Our physician advisors are on-site. They call up the requesting physicians, discuss it with them. And if a denial is still approved by the physician, then there is always a reconsideration process. The reconsideration process -- I heard someone express a concern today that there should be an outside agency to

arbitrate these. We always submit the reconsideration to a separate physician who is specialized in the area where the patient needs the service. There is also an appeal right, where the member can actually have their case reviewed by the medical director through a committee.

I think one of the important things, at least what we try to do at Blue Cross, is to try to partner with the physicians. Most of what I've heard today, I think, is an antagonism between the HMO medical groups, the physicians. I think it's very important that our physician network know that we're there to work with them and we're not there to work against them.

On the concurrent review side, we have nurses who specialize in reviewing cases for members who are in the hospital. We all know -- American studies have proved that -- I'll summarize this in just a second -- that long hospital stays are not that beneficial to members. There's the opportunity for them to contact other infections. We do work with the case management staff at the hospital and the UR staff at hospitals to do what is best for the patient as well as for the physician who is handling the case. Thank you very much.

DR. ENTHOVEN: Thank you very much, Ms. Palm.

Our next speaker is Dawn Wood, M.D., followed by Celia Irwin.

Dr. Wood.

DR. WOOD: I'm Dr. Dawn Wood. I'm pleased to be here tonight. I'm here basically to let you know

that I'm a medical director for Blue Cross Medi-Cal managed care plan. I'm an associate professor at UCLA, and I have a small clinical practice.

My message for the committee is that I feel managed care has improved the delivery of health care in California. And I would like you to keep in mind, when you're forming your recommendations, the following:

That any recommendation should help the continuing evolution that's occurring in health care delivery and the improvement that we will all want to see. I also would like to say that I don't want to hinder the health care delivery system in any way. We want to allow free-market competition to take place so that we can have better health care delivery products. And also that, under the fee-for-service system, we did -- the fee-for-service system certainly did not meet the quality of care standards that we hold managed care organizations accountable to today.

I'd like to elaborate on these recommendations from two points. One is a practicing physician. I've been in private practice since 1982. I've seen a lot of changes in the health care delivery system. And what I've -- what I feel is that managed care certainly improved it. And I'd like to underline it with the fact that, when managed care came into UCLA four years ago, I was not -- as a practicing physician, I was not enthusiastic about it.

Change is hard to accept. But what I found,

despite the fact that I had to fill out many more forms, was that I was kept in the loop of what was going on with my patients, that no services were being render that I did not know about or think were medically necessary, and that I could talk with my patients before they had a procedure done.

In the fee-for-service arena, the patient would go to a service provider and made access care that really was -- they did not have my input to. So I think that's improved my role in care. And I feel that I can give a medical home to patients that I couldn't under the fee-for-service system.

I'd also like to say that in the fee-for-service system, a lot of doctors did not give the kind of access to care that we did in managed care. Fee-for-service system doctors after hours would often sign out to emergency rooms. And they may or may not be available to admit their patients when an emergency occurred and a patient had to be admitted to the hospital.

Under managed care, physicians are required to be available and to have a system for taking care of their patients in the hospitals.

I'd also like to address the issue of managed care from the point of view of a medical director for a Medi-Cal managed care program who process program. And what I feel is that we really have improved the medical health care delivery system.

I've worked in a lot of different health care

systems. And when I worked as a consultant for the World Health Organization -- I also worked in health care delivery systems for various developing countries. And what I see is that the real important thing is to develop a health care delivery system that will work and --

DR. ENTHOVEN: Could you please summarize, Doctor.

DR. WOOD: I'd like to say that in the Medi-Cal managed care system, we have improved access to care. We allow members a broader selection of providers. We do incorporate traditional and safety net providers in our network.

In summary, my recommendation to this committee is to keep in mind that we will all want to improve health care delivery systems and that Medi-Cal managed care and managed care in general, I think, has gone a long way in improving the system.

DR. ENTHOVEN: Thank you very much.

Our next speaker is Celia Irwin. Is she here?

Next speaker is Martha Ronk. Is Martha Ronk here?

Our next speaker is Pamela Broaderson, United Nurses Association of California.

Sue Glenn, United Nurses Association, and then we'll have Rhonda Good on deck.

MS. GLENN: My name is Sue Glenn. I come from United Nurses Association. I've been a critical care

nurse for 18 years. I was a nursing assistant before that. So I've been in the medical profession for a long time. And I've come here today to express our great concern as registered nurses over the change that we have seen in the medical profession. We are not able to deliver the care that we feel is necessary to keep our patients healthy and safe.

What I'd like to address is the basic problem of giving education to our patients. There is multiple things that happen when you don't have a registered nurse at the bedside. And I believe that's already been discussed today. So I'm not going to go into all those things. But our education piece is a big concern for me.

I see that, with the limited amount of staff, the change to the skill mix, the limited amount of time that we are able to go in and actually spend time with our patients has reduced the quality of care that we can deliver.

We are all very extremely frustrated. We see the changes unnecessary. And it is cost-driven. We don't feel that what we can give is what we should be giving.

We want to be able to be out there to go in and spend that time to get that patient safely out of the hospital, safely out of the clinics, safely out of the nursing care homes, back home where they belong where they can be able to manage themselves. This is not happening.

We see patients over and over again being sent out critical care sicker, into the medical floor

sicker, and home sicker. They don't have people to take care of them. You have disabled families trying to take care of disabled patients.

There's a serious problem here. And I seriously hope you look into what you've been charged with here to do for this -- for the HMO's to review what's going on today and to let you know that the registered nurses are leaving the profession because they are scared of what's happening out there now. You're not going to see the registered nurses that have been in this profession for a long time be there to help the new nurses coming in to support that important piece of continuing education between nurses to nurses.

This is a serious situation. And I can't stress how serious and how sad I am that I have to be here today to express these concerns. I've always been very proud to be a registered nurse, and I want to go on being proud. And I hope that this process changes, and changes soon.

Thank you very much.

DR. ENTHOVEN: Next, Rhonda Goode, followed by Matthew Margulies, M.D.

MS. GOODE: I'm a registered nurse, and I work in a critical care area in an acute care hospital for a large HMO.

I just want to concur with the previous speakers who are fearful of a wholesale vetoing of the bills before the legislature to protect patients.

I personally can say that I've seen a patient spend 16 hours on a stretcher in a recovery room because he didn't have a bed in ICU because we closed down two of our ICU teams. I've seen mothers and babies sent home after eight hours, regardless of circumstances.

I've had a patient who was 80 years old and had heart surgery, had an open chest wound that needed a dressing changed three times a day, and a 78-year-old wife is informed that she was going to have to be the one to do it, in spite of the fact that she had expressed her terror of doing that and inability to follow instructions about how to do it.

I had a patient who was due for discharge who began to look unwell. And when I discussed the patient with the doctor and we got a blood pressure which was a little lower than it should be and a heart rate that was faster than it should be -- this is a post heart surgery patient -- where the doctor said, "What do you think? Should we keep this patient here?" And I said, "Yeah. Let's let her stay overnight." And the doctor said, "I think I'd better discharge her because, when they come around in the afternoon to check the bed availability, I'm in big trouble if she's still here."

For those reasons, I think the bills currently in front of the legislature, if they're vetoed, will cost lives. There's a possibility of saving lives by passing some of the legislation.

The other area that I just wanted to briefly

talk about is the subject of JCAHO. They currently inspect and accredit acute care hospitals. And I understand that there's a possibility that they may be the ones to accredit and be the teaming agent for convalescent hospitals. Personally, I find this a very frightening idea.

Any of us who actually work in hospitals can tell you that as an agency to accredit and inspect hospitals, JCAHO is, frankly, a joke. It's a private agency and funded by the hospital. You can have a preinspection for a fee, to tell you where you need to improve before the formal inspection.

The visit is preplanned. The hospital where I work is due for accreditation by JCAHO. It's going to occur in November. And in a couple weeks, we'll probably know exactly what days it will be happening. And there are currently extra staff now correcting medical files making sure evaluations are up-to-date, policies and procedures are what they should be and that all the staff in the hospital is prepped in what the questions are of the JCAHO this year. That's not what's needed, I don't think, to make sure we're running high-quality hospitals.

I think that the state, in whatever agency, needs to be the accrediting force that there need to be enough inspectors to adequately deal with the hospitals, that there be unplanned visits. Because I'm very concerned particularly, I think, with convalescence, that the state currently licenses them and is able to provide

fairly heavy fines if they aren't complying with the rulings.

If we start doing the same thing with convalescence as we're doing with acute cares, I think we're in for a very dangerous situation. I'm very hopeful you'll recommend to the state that some agency be the ones to accredit all hospitals in the state.

DR. ENTHOVEN: Thank you very much.

Matthew Margulies, followed by R. Lloyd Friesen, D.C.

DR. MARGULIES: Thank you very much for the opportunity to talk to you and for taking the position of not impending current legislation on HMO reforms. I want to address -- although many issues are very important that have been mentioned today, I'm just going to mention two, and tie them together.

The issue of termination of physicians or social workers or nurses without just cause, I think, is very important. And I think that that ties in very closely with the physician-patient relationship. I've been practicing for 37 years, and I know that that relationship is based upon trust and respect. And when there is a continuity of care -- knowing a patient's history knowing, what they've been through in the past, knowing the results of prior treatments, prior complications -- this leads to dealing with the situation at hand now. When you have to recommend a diagnostic procedure or therapy, it's based upon what you've already

experienced with that patient.

It cannot be based upon cost containment. If you're going to be an advocate for the patient, you have to be conscientious and caring about that patient. You cannot be concerned with the bottom line.

I think that's everything in a nutshell.

DR. ENTHOVEN: Thank you very much, Dr. Margulies.

Next speaker is C. Lloyd Friesen.

DR. FRIESEN: I'm Dr. Lloyd Friesen, sole practitioner 27 years in Thousand Oaks, California. I'm here as the director of government affairs, Department of California Chiropractic Association. Just touched on a couple issues here today.

First of all, the issue of continuity of care. The California Chiropractor Association sponsored chapter AB-1152 -- that had to do with continuity of care for patients who had their providers changed through no part of their own. It was employers changed the health care benefit plans.

We are presently in support of SB-1129 by Brian Sheer, which has to do with the continuity of care issues when the patient is presently in the plan.

Number two, access issues. It's our opinion that patients who have direct access to all providers, irrespective of category of licensure. There are a number of statistical studies that have been done, scientific literature that shows that non-M.D. providers can provide

good quality health care in an efficacious manner.

Number three, enrollee's right to information. Previous comment was made that the information that an enrollee receives and what they understand are light years away. And that is falling more and more to providers such as myself, who is a sole practitioner, to try to determine the benefits of the patient and interfering with the patients and determining their health care needs.

With respect to the provider issues, there seems to be a dichotomy with respect to the termination of appropriate health care and necessity of care. Many health care or managed care companies lock out new licentiates that have not been in practice three, perhaps five years. However, on the other side, they're having people that are doing the review of medical care that are fresh out of their respective college or schooling.

We feel that either one or both of those issues needs to be dropped. With respect to medical director bills in the legislature, we are in support of those bills, with the caveat that they be placed as provider neutral bills. Because, again, many non-entity providers are participating in the health care delivery.

Finally, with respect to termination without a cause, California Chiropractor Association is a cosponsor of AB-434, by Assemblyman Gallegos, which has to do with inappropriate and -- termination without cause of providers.

In conclusion, my comments, I would suggest, show that we are in support of change in the managed care industry as long as several caveats are attained. Number one is that legislation should be provider-neutral. Again, there are a number of non-entity providers that are rendering good quality efficacious health care.

With respect to governor's situation and his suggestion that various bills will be vetoed, certainly, if they are, we would ask your consideration in your final report that the bills that I previously mentioned as well as SB-977, by Senator Piece, as it relates to the overhaul health care delivery system changes, and attempt to do it in a cohesive manner rather than piecemeal.

DR. ENTHOVEN: Thank you.

Our next speaker will be Bob McCloskey, followed by Ira Horn.

MR. McCLOSKEY: My name is Bob McCloskey. I want to thank the task force for this opportunity to today. I want to speak both as a HMO member and also as a union representative of health care professionals, including registered nurses, for the last 10 or 12 years.

I wanted to speak to the patient-physician relationship issue as well as trends and changes in health care industry.

My physician, who is contracted with various HMO plans -- Secure Horizons, Blue Cross, Blueshield -- recently wrote an article in the local community newspaper about the reasons why he left his HMO as a contract

physician.

This is after I had been with this physician for a number of years. He's treated my family. We've had problems getting care through Blue Cross, CaliforniaCare. My wife was hospitalized for major abdominal surgery. Every day after the second day, after the first day she was in there, the HMO was calling my physician and asking to send her home.

He, of course, insisted that she stay in the hospital an additional two days. She was able to stay four days. But on the third day, again, they were harassing him, in my opinion, to send her home. She was on double antibiotics and had a major wound incision and had major abdominal surgery.

In addition to that, my daughter had a precancerous condition of the cervix. He had to lobby hard. And it took a year to get the proper procedure done for her. After years of frustration with the HMO -- and he's got more examples in his article and the community paper -- he talks about a woman who had a sign of lung cancer on her X ray. The HMO refused to grant an X ray for her. He recommended a biopsy and another cell abnormality situation with another patient. Finally, he said "In order -- I came to realize that keeping this up meant me having to kill my conscience."

Eventually, he did quit his HMO. He quit all the HMO's he was contracting with. He felt that they were eliminating his ability to practice. And, unfortunately,

unless we go out of our plan now, we cannot go to him as a physician.

I think -- I'm a representative of Kaiser Permanente, Los Angeles Medical Center. They're a premiere tertiary facility. I think one thing that's been touched on today is the system. I think the system is driven by profits. There's a 1995 article in the "Wall Street Journal" about the HMO's amassing large amounts of cash. Kaiser had $2.3 billion in 1995. The other HMO's had cash in upwards of $12 million, total -- FHP, Cigna, and the other ones. The cash accumulation is an outrage. The executive salaries they're paying is an outrage. Kaiser's had a goal since 1995 to cut $900 million out of their budget, $300 million to come out of labor costs and $600 million out of patient care.

I'll try to wrap this up. As we see in the hospital, it's dramatically impacting staffing. Patients to nurses ratios have increased. The hospital does not staff by severity of illness, as required by law. They've been cited. The State Department of Health Services does not enforce these citations. They come up with a plan of correction on paper, and that's it. Nothing happens. They still continue to run the hospital short-staffed.

The earlier release that we see -- now cardiac open-heart patients going home in four days that used to be kept eight days. We see -- like one of the earlier people testifying mentioned, new moms and babies sent home in eight hours. That was Kaiser that started

this.

They started this program when they had $2.3 million in the bank. This is not about HMO's being broke. They have plenty of money to provide adequate care. They put people on care paths, standardize their protocols and procedures, sending people to nursing homes. Total hip placements go to a nursing home in one day now -- the language in a convalescent home with substandard care where there's very few licensed personnel. These kind of patients used to stay in the hospital.

These are the changes in HMO's I've seen personally in the last three or four years. And I think this kind of procedure needs to be address. I encourage you to look at all these issues. Thank you very much.

DR. ENTHOVEN: Ira Horn, followed by Doris Gilbert.

Okay. Doris Gilbert, followed by Terry Elias.

MS. GILBERT: My name is Doris Gilbert. And I'd like to relate several situations which represent our experience as patients. I won't recount a single catastrophic incident to illustrate my frustration, disappointment, and distrust of managed care but, rather, a myriad of management muddles and prevention of access to efficient and effective treatment which I feel is the more pervasive problem with managed care.

First, my daughter has severe diabetes, with

multiple medical problems, and also clinical depression, requiring frequent hospitalizations. She couldn't get immediate ongoing access to her endocrinologist but would have to wait weeks for approval each time. That was an impossible situation.

Once, my daughter was suicidal and needed to go to the hospital. I called her HMO psychiatrist, who doesn't do hospital work, and followed all his instructions. First, the HMO incorrectly stated her benefits were exhausted. Fortunately, I knew this was incorrect. I called three doctors from the list to be her attending physician and got turned down by each, taking three hours. It took nine phone calls and eight hours to even be approved to go to the ER, then another four to be admitted. This was an agonizing situation for me. And I felt we couldn't get any help. Imagine if the patient had to do this for herself.

Third, according to HMO rules, to be admitted to UCLA neuro psychiatric institutes, she had to be medically cleared by the ER. But it had to be at Santa Monica Hospital's emergency room, necessitating a wasteful ambulance trip to UCLA.

Also, it was impossible to have the same psychiatrist in the hospital as for outpatient therapy. This is efficient, effective treatment?

Our employer changed our insurance, necessitating all new doctors. Just then -- vomiting landed my daughter in the Santa Monica Hospital ER. She

explained she had been vomiting on and off for six weeks. The doctor said "It's stomach flu. That's what's going around." It was all wrong. And discharged her, vomiting, in a wheelchair because she was too sick to walk. The next day, still vomiting, she went to the doctor's office. She was given an IV, spending three hours on a hard examining table, unable to stretch out full-length.

Time and time again, we were incorrectly sent bills and threats to be sent to collection. It took 60 phone calls and six months to straighten out the mess. Finally, not all our complaints involved complicated and serious chronic illness.

Another inefficiency of the HMO in a relatively minor, but a lesser, situation, my husband went to his primary care doctor for a skin condition. When the prescribed ointment didn't work, he returned to the doctor, who applied for a referral. It was denied. No reason given with instructions to return to the primary-care physician.

Upon probing, I discovered the denial was due to an incorrect Social Security number. That rectified, he went to the approved dermatologist, got another ointment that also didn't work. Finally, after one month, he went out of network, paid out-of-pocket, and the condition cleared promptly. Managed care life-threatening? No. Efficient and effective? Certainly not.

I have many other stories to tell. Medical

care is supposed to relieve suffering. Our experiences with managed care greatly intensified anxiety, frustration, and real suffering. Thank you.

DR. ENTHOVEN: Thank you.

Next speaker is Terry Elias, with Gordon Schaine, M.D., on deck.

Gordon Schaine, M.D., with Mary Carr on deck.

DR. SCHAINE: Thank you. I come to you from the vantage point of 12 years of private fee-for-service medical practice and then 12 years of managed care practice. I am -- I'm not going to give you a list of boards and titles, but I am on the board of my local medical society, which is part of the Los Angeles County Medical Association.

I'm an advocate of doctor-owned, doctor-supervised managed care medical groups. Managed care, as you state, has reduced the cost of health insurance by 25 percent in the last three years in California. The managed care that I see is terrific. Our patients have over 95 percent satisfaction rate. We receive a steady stream of letters from grateful patients.

Now, what you ask is for us to address what is the system? How can we improve the system? The system that I suggest is once, again, doctor-owned, doctor-supervised managed care medical groups. The decision for all surgeries in these groups, all tests and treatments is made within 24 hours by the doctor, with consultation from the patients.

No outside approval is needed. This is the way our group works. We have 300,000 patients. Second opinions are always available. Once, again, second opinions are always available. No medical care is restricted. None of the patients have unnecessary surgery. None of the patients have unnecessary tests on multi-million dollar machines the doctors own and need to pay for. No doctor has used any insensitive for withholding care. None of our doctors receive any incentive for withholding care.

Each patient's care is monitored by ten full-time nurses and counselors. Entire medical group is then monitored by outside quality assurance agencies. I want to point out that there is no monitoring of quality care from private practice.

I personally know of two private practice cases in the past year where patients had sinus surgery and had their brains perforated as a complication, and there was no need for the surgery. The only indication for the surgery by private practice doctors was the presence of private insurance.

Rarely, a hospital case is brought to a review committee, and the doctor gets a slap on the wrist. The state medical boards mainly judge felonies and doctors with substance abuse. Managed care groups have layer upon layer of quality control. I ask who would you rather have treat you? What type of medical practice is protecting you and me from unnecessary surgery and from inappropriate

medical treatment?

We've heard a lot of criticism today about managed care. A lot of doctors who are putting aside managed care unfortunately are the same doctors who are losing their livelihood to managed care competition. It's a bad situation. But we need to know this. It's a big surplus of doctors in Los Angeles, a big surplus of surgical specialists in our cities. And the latest scare is that HMO's are using the profit motive.

I was in private practice for 12 years. I know private practice doctors with profit margins over 100 percent. The answer, in my opinion, to affordable quality care we all need and deserve is presently being provided by the doctor-owned, doctor-supervised managed care groups. Just remember, during the doctors' strike of California, the patients' death rate dropped by 50 percent. Proof that unnecessary care is not better care.

I feel that managed care is good for our patients and good for our patients' health, and it's good for or country and for the economy. Thank you.

DR. ENTHOVEN: Thank you, Dr. Schaine.

Dr. Gilbert.

DR. GILBERT: Thank you for coming. How do you address the issue? Because all IPA's, by law, are either doctor or doctor-owned -- multiple doctors --

DR. SCHAINE: Yes.

DR. GILBERG: -- we certainly heard anecdotal testimony. And as a medical director of an HMO, not all

doctor-owned IPA's are equal. Some are better than others. Some, unfortunately, I think, use economic incentives, use risk pools, use different methodologies.

So what I want to know is you've got something that works. How do we as a task force think about how to make that work across the board? Because not all medical groups are created equal?

DR. SCHAINE: I think your group should establish some criteria as to what you want, what the minimum criteria are in the state for effective medical care. And I think that's one of the things that you might be charged with. And you can take the leadership as to what the minimum criteria are, to take the incentive out of managed care, to make sure that all care is available. And the way we do this is very, very efficient. And you increase deficiencies. And sometimes the doctors in our group take a loss. Okay?

You have to be prepared for this. You have to -- you have to tell us what to do and provide some guidance. I think the larger the group -- the smaller groups don't work effectively. If you're a very large group and you can be more efficient through each huge computer systems, having medical records instantly available, yes.

DR. ENTHOVEN: Can you write us with what the criteria should be?

DR. SCHAINE: I will.

DR. ENTHOVEN: Thank you.

Next is Mary Carr, deputy director of Ventura County Medical Society, followed by Damiana Chavez.

MS. CARR: I'm Mary Carr, with Ventura County Medical Society. Over the last three years, probably the most active committee that we have is our insurance grievance committee. The things that we've been seeing is that, even though a physician may hold a contract with an HMO or an IPA, holding that IPA or HMO to that contract has been next to impossible. The HMO's and the IPA's arbitrarily decrease benefits, decrease co-pays that the physicians are counting on from the patients.

But by the time they do get authorizations, after they go through the denial process, the appeals process -- and by the way, we're much in favor with what has been stated here about having standardized appeals process.

The average physician in Ventura County holds about 40 different contracts. Every contract has a different appeals process. So if they're confused, so are the patients. It makes it next to impossible for the physicians to help the patients.

The gag clauses had to be eliminated by law. The physicians want the patients -- they have been. That was legislated.

DR. ENTHOVEN: That was legislated last year.

MS. CARR: That was legislated. And the thing is that that was supported by the California Medical

Association and the AMA. The physicians want to be able to discuss the full range of care and the why's and wherefore's with the patients. Many of the patients, especially under capitated contracts, are thinking, well, the physician is being paid big money. A lot of those capitated contracts, the physician is getting paid anywhere from $6.00 to $30.00 a month per patient.

And if a patient comes in and if they're ill within the first couple of months, that physician -- it's costing them to care for the patient. And many instances we have -- and I do have documentation here that I'll leave at the desk -- is that the physicians, they continue to care for the patient if they feel the medical care is justified, regardless of denial.

Then they have to fight or help support the patient in getting reimbursement, just as what was presented to you earlier. That's more the norm in many situations.

One of the things that is on an authorization letter once you do get authorization, is it states "This letter does not guarantee payment." So what's the use of getting the letter? And we have copies of that here for you to see.

Managed care. Managed care has taken this pendulum swing from indemnity, which you were talking about the California PERS program going from indemnity over here to HMO. Somewhere in between was called PPO, and there's very few of that out here.

If you take PPO and have a stringent utilization review authorization on it and eliminate the capitation, then there's no longer a conflict of interest on the physician's part in making a determination of what care a patient is going to get.

The other thing, just one more quick comment, is that regulation and monitoring of the HMO's and implementing any of the law, right now there is a law that states an HMO and IPA must make payment within 45 days.

We have contracts with the foundation for -- Foundation Health care from Sacramento. One year ago they submitted letters to 1,000 physicians, offering 50 percent payment, 50 cents on the dollar, which equaled out what was due was $3.5 to $4 million.

It's going to have to go through legal channels in order to hold their feet to the fire for that. So there does need to be a monitoring system for that.

DR. ENTHOVEN: We'll have to get into that. Thank you very much.

Next speaker is Damiana Chavez. Thank you very much for coming.

Followed by Barry Levy. And before I start your clock, I've been informed that the garage downstairs closes at 7:00 P.M. And --

DR. GILBERT: Quarter to 7:00.

DR. ENTHOVEN: It closes at a quarter to 7:00? So just warn people who have cars.

MS. CHAVEZ: I represent no one. I'm

Damiana Chavez. I'm 64 years old. I have rheumatoid arthritis. And I came to say that Kaiser Permanente has never tried to make me disappear. I was diagnosed in 1976 with rheumatoid arthritis when I was under Blue Cross coverage. I joined Kaiser in 1978 and received fine treatment from the get-go. But especially in the last five years, care has been terrific. Even with medication, over the years, my fingers and my feet deformed. But until being laid off by UCLA in July of 1992 at age 59, I continued working.

In late 1992 I was actively looking for other employment because turning my neck became painful; Walking, difficult; and holding a pen became a task. My primary-care doctor at the time referred me to orthopedic for X rays of my shoulders and lower neck.

On a second visit, that surgeon ordered X rays of my upper neck and saw that my C-1 and C-2 vertebrae, the crucial ones that hold the spine in place, had separated. He referred me to neurosurgery. In 1993 a neurosurgeon successfully reconnected the vertebrae with a small piece of grafted bone, two screws, and a wire.

I'm not working now, but I walk and I talk. My care includes regular appointments in rheumatology, podiatry, and primary care. And yearly mammograms, eye examinations, and X rays of my neck.

Occupational therapists replace my hand splints as needed. And I do my part -- balanced diet, sensible weight, sufficient rest, exercises, and

medication as prescribed.

You know, after hearing some of the accounts that I've heard today, I just have to wonder what condition I might be in if Kaiser Permanente had shoved me aside or tried to make me feel that I wasn't worth working on. Kaiser's doctors have been simply wonderful to me, and I had to come today to say that.

Thank you.

DR. ENTHOVEN: Thank you very much.

I think I figured out why some people have such good experiences and some people don't. If we could figure out the magic key here, it would be wonderful.

The next speaker, Barry Levy, followed by Nancy Greep, M.D.

MR. LEVY: Thank you. It's been a long day. My concern seems to be with regulation and control of HMO's and the failure of the state regulatory agencies to protect the public.

Monday "Pavia Villa" died -- following that up, find out that it's not even registered with the Department of Corporations as an HMO in the state, even though it's acting that way by offering multiple offices and dental plans for HMO-type enrollment.

My experience with Western Dental, which recently was fined, was that in September of '92 the Department of Corporations knew that Western Dental, since 1988, was operating in a clinically non-acceptable manner. And their reports showed that the best case scenario was a

50-50 chance of having adequate treatment.

So what we have now is nine years of denying neglect on the part of the Department of Corporations, with numerous patients being harmed. And my questions are, when we come into HMO's and otherwise, who is protecting the public? And are these patients that have been harmed going to be informed? And how are corrective measures going to be taken?

Another example with another dental HMO, which was Consumer Dental Network, now doing business as Newport Dental Plan, took five years, despite instances of fraud, abuse, unlicensed personnel, in order for the Department of Corporations to issue an injunction to prevent them from working. My understanding that the injunction was brought about due to the fact that there was some financial irregularities. Nothing to do with unlicensed personnel, quality of care, fraud, and abuse.

We've run into some serious problems here. And we're going to always have the fact that HMO's are businesses. And unless we have regulatory agencies looking over the shoulder, adequately protecting the public, they will push the envelope as far as they can to make money.

I'm no longer concerned about HMO's doing business as business. That's their job. I'm concerned about the state setting themselves up as regulatory agencies and fail, and fail miserably.

Thank you.

DR. ENTHOVEN: Next speaker, Nancy Greep, followed by Virginia Whittig.

DR. GREEP: Thank you for this opportunity to be here. Again, my name is Dr. Nancy Greep. I'm a physician who's been in practice for 20 years in a variety of settings, including a non-profit staff model HMO, a university hospital, and also in private practice.

It's late. It's hot. And I -- as you request, I will be brief and to the point. I'm not going to tell you anecdotes, but I will be more than happy to at some other time. I'm basically going to you how I feel as a physician. I'm going to give you briefly what my analysis of what the problem is, a brief solution.

How do I feel about the medical care today, with the dominance of managed care in California? I feel badly about it. I'm angry about it. I'm upset. I feel my ability to deliver quality comprehensive, sensitive care has been seriously compromised.

That contrasts with when I first came out of medical school, if I can make an analogy. When I first came out of medical school, I think I felt somewhat like a shepherd with a flock, that I could direct to the best pastures and help to protect against harm. I now feel my role has been to change to more of a cattle hand who is basically herding a bunch of cattle to a variety of pens, who are ultimately off to market.

Would do I feel is the problem? I feel that the essential change in the medical care scene is the

invasion of the health care industry by corporate for-profit medicine. It's very clear that what is going on is that managed care is mostly interested in managing medicine, not in order to provide quality care, but in order to maximize profit and decrease costs.

So what is the solution? What is the solution? We have short-term solutions, which is mostly what we've been talking about today. And it is true managed care and for-profit medicine is very much here, and we have to deal with it here and now.

So I think it is important to come up with what I see as short-term solutions. And these would be to follow through with the patient care Bill of Rights such as the legislature is trying to accomplish.

However, I think it's important that we stand back and that we not lose sight of the forest for the trees. What is the problem here? The problem is not managed care. We are all for managed care in the sense that, in order to have quality care, we need to have care that is delivered in a comprehensive, coordinated manner.

The problem here is not managed care. The problem is before profit in the managed care, and that's what we need to take out. So if you want recommendations about how to solve this problem, it's to remove the for-profit mode from the managed care industry.

For example -- we know that, for example, the non-profit HMO's, they put back in something like 95 percent of the dollar back into the system. And that

system works just fine. When we have only 70 percent of the dollar going back into the system, it doesn't work, and we have all the abuses that you've heard about. So one suggestion.

A long-term solution, I think, would be to have some effort to try to limit the amount of profit that the managed care companies are allowed to take out of the health care business. And another way of saying that would be to make recommendations to ensure that they put a certain minimal amount of money back into the health care --

DR. ENTHOVEN: Please --

AUDIENCE MEMBER: -- industry. And that is what -- my conclusion.

DR. ENTHOVEN: Thank you.

Virginia Whittig, followed by Jim Marx.

MS. WHITTIG: My name is Virginia Whittig, and I really applaud your endurance. I am the immediate past president of the California Association of Psychiatric Mental Health Nurses in Advanced Practice. I have a private practice in Woodland Hills here in the San Fernando Valley.

The goal of managed care is to provide cost-effective care. Non-medical licensed health care providers are underutilized sources of cost-effective care. These trained and highly skilled providers include advanced practice registered nurses, such as nurse anesthetists, nurse practitioners, nurse midwives, and

clinical nurse specialists such as myself. Other medical providers include social workers, psychologists, physician's assistants, physical therapists, chiropractors, and registered dieticians.

Patients have difficulty assessing us as cost-effective, non-medical providers due to five main barriers that continue to exist today. One is that not all managed care plans accept each category of license into their provider panel.

Second, not all plans list these non-medical providers in their provider directly, even if the category of license is accepted by the plan. For example, this is a provider directory for "Champus." I am on their provider panel, and I have been for two years. My category of license is not listed in this. My name is not listed even though I'm a certified "Champus" provider of services. Any patient who would want my services would never find out, looking through this booklet.

Number three, of the category of licenses that are not accepted, a managed care company may still allow a patient to select a non-medical provider of services, but will usually require that the patient pay a higher co-payment for seeking an out-of-network provider.

Four, if a plan does not make provisions for out-of network providers, the patient is required to pay the full cost of treatment despite his efforts to seek cost-effective providers.

And, five, and lastly, if a managed care

panel is closed or full, as is common here in the Los Angeles area, equally qualified medical and non-medical providers are turned away thereby, once again, limiting a patient's access to qualified help.

DR. ENTHOVEN: Thank you. I hope you are summarizing. You said "finally."

MS. WHITTIG: Okay. The "Coleo" bill, which was passed a year ago, was a very big step in the right direction. And I'm hoping that this task force will continue to look at these problems and broaden the access to care for all non-medical providers.

Thank you very much.

MR. MARX: I'm Jim Marx. I'm just a patient. So I'm not an R.N. or a doctor or anything else. But I'd like to tell you what happened to me. Four weeks ago yesterday, I had total hip replacement. I was being forced out of the hospital after two days against the evaluation from my nurses and rehab people. I assisted my physicians in that decision. Consequently, three weeks ago yesterday I was out without any kind of type of medical attention after having a rather severe surgery. My doctors refused to see me or take my calls.

One day, though, I finally managed to secure myself with medical attention. A tragedy did not happen to me, but at all times during the past four weeks, a tragedy could have happened to me. My reason for coming here today is that I urge everyone to make sure that reform happens. Because you don't know when it's going to

happen to one of you or one of your loved ones.

Don't let this happen -- what happened to me happen to anybody else. Nothing terrible happened to me. Something terrible could have. Don't let a death or somebody being handicapped be the solution. Listen to my story instead.

DR. ENTHOVEN: Was there a lot of preparation ahead of time? Did you go you through pre-habilitation?

MR. MARX: I had nothing. I had no information provided to me before my surgery except that -- what I had to find out on my own. My surgeon wouldn't even tell me what to expect when I was going to wake up from the anesthesia. I had no idea what was going on with me. I had to go and find out on my own, do my own leg work -- obviously, an ironic situation -- to find out was I going to be in pain when I woke up? I didn't know.

And my doctor provided me with so much misinformation and so many misdiagnosis and problems to the extent, my primary-care physician prescribed medicine to me for two years over the telephone before I ever once went into his office to -- because he's too busy, too many patients. I said "I'm sick. "Go to your pharmacy."

That's not a good system. It needs to be reformed.

Thank you.

DR. ENTHOVEN: Thank you.

MR. MARX: Thank you.

DR. ENTHOVEN: Next we have John Bibb, M.D.,

followed by Robin Doroshow, M.D.

Is Dr. Doroshow still here?

John Bibb.

DR. BIBB: I'm Dr. John Bibb. I'm an emergency physician. I'll tell a quick story and make a suggestion. A 57-year-old female was being worked up by her private physician for labile emotions and weakness. She got worse. Her family was concerned. They took her to emergency department A. At emergency department A, there -- the covering physician for her doctor was contacted. He denied the visit said that her insurance did not work in the emergency department A, but it did work in emergency department B. Therefore, the patient and the family went to emergency department B.

At emergency department B, before the physician saw the patient, the covering physician called and denied the visit. The patient was complaining of weakness and hurting all over. It was a difficult diagnosis. It finally turned out that the patient's serum sodium was 113. This is a severe electrolyte abnormality. It can cause seizures, death, so forth. The treatment is actually difficult and is often done ICU. The covering physician was called back, told what the serum sodium was, and immediately admitted the patient to the hospital.

So this is a complicated case that brings up a lot of issues. I will just make a suggestion. There's legislation called "Prudent Layperson" legislation. What that says is that, if a patient reasonably believes that

they have a medical emergency, then they should be allowed to go to an emergency department and receive a screening exam to see if they indeed do. If they do, they should be allowed to receive stabilizing medical treatment.

DR. ENTHOVEN: I thought the reasonable person standard was a part of the law of the state.

DR. BIBB: That is correct. It is contained in the Bergson Bill 1832. And it states that -- it states that this applies to plans that do not have a contract with the emergency department where the patient goes.

All right? So, in other words, if you go out of plan to an emergency department, it applies. If you go in plan to an emergency department, it does not apply.

DR. ENTHOVEN: The reasonable person standard doesn't apply?

DR. BIBB: Does not apply if you go to your plan emergency department. That's correct, it does not apply. Further, it does not apply to ERISA plans. It does not apply to ERISA plans. So it's out of plan. Recently in the Federal Budget Act that just passed, it now does apply to Medicade and Medicare HMO's, but it does not apply for in-plan visits.

We believe that this does need to be extended to in-plan visits. That's my suggestion.

DR. ENTHOVEN: Thank you.

Robin Doroshow, M.D., followed by Dorothy Frisch.

DR. DOROSHOW: Thank you. I applaud your

endurance, and I hope you appreciate mine. Match you hour for hour and rote for rote.

I'm speaking to today as vice-president and president-elect of California Chapter 2 of the American Academy of Pediatrics. And I represent about 1,600 board certified pediatricians and pediatric subspecialists in the greater Los Angeles area.

I'd like to speak today, not as an advocate for pediatricians, but as an advocate for kids, which is what I do most of the time.

And I specifically would like to be an advocate today for the small minority of children who have special health care needs, not necessarily chronic needs, but needs of a pediatric subspecialist. In the 24 years since I graduated medical school, there has a been a very, very dramatic improvement in my field, pediatric cardiology.

Enabling us to save a vast majority of children born with even very, very complicated heart defects. And the advent of things like echocardiography to allow us to make diagnosis a minimal or no risk. The advent of pediatric heart transplantation, which I participated in at Loma Linda and so forth. And this has been well demonstrated to be very cost-efficient. That is, you get more bang for your buck doing an open heart operation on a baby in terms of the number of productive years for dollars spent than virtually any other form of medical care. I'm not trying to toot my own horn because

I personally didn't contribute to that. But I'm certain my patients benefit from it all the time.

However, in recent years, particularly in Southern California, I've seen a reversal of this trend which, I believe, is related to the fact that many managed care organizations do no offer access to pediatric subspecialists such as myself.

I apologize if some or all of you understand these facts, but I feel it's important for the record, if nothing else, to clarify that pediatric cardiologists, for example, are not cardiologists who choose to take care of kids.

We are first fully trained and board certified pediatricians. We take care of infants, from two pound premies on up to 200 pound teenage football players. And also fetuses, in some cases.

In addition to that, the kinds of problems we treat are entirely different. And this is true for most areas. For example, there are pediatric hematologist oncologists. There are pediatric gastroenterologists, and on and on. There are a lot fewer of us. So we don't have as large a voice. But we are trained to take care of different problems. And adult cardiologist takes care of coronary disease. And I assure you that, if I would have a heart attack, I would go to an adult cardiologist, not one of my colleagues. On the other hand, if I had a blue baby born to me, I would go to a pediatric cardiologist.

DR. ENTHOVEN: Please summarize.

DR. DOROSHOW: Yes, thank you. I just would like to make you aware of this issue and ask that you consider the requirement for availability of access to this type of service and the definitions of these types of special needs, even though they do apply to the minority of patients. They make an enormous difference to our population.

Thank you.

DR. GILBERT: One quick comment to this is that the DOC, in its required specialties that HMO's must have does not require pediatric subspecialty. It only requires the adult specialists.

DR. ENTHOVEN: Okay. Good point. I'm wondering how do we get a handle on that? Okay. Next, Dorothy Frisch. Is Dorothy Frisch here?

Liz Torres?

Judith Porter, followed by Ralph Reece.

MS. PORTER: I'll start from over here just to save time.

My husband is a solo practitioner of obstetrics and gynecology. I've been his office manager and helpmate since 1972, along with the pediatric cardiologist. The plans do not have perinatologists. My husband is a normal obstetrician. When we need perinatologist not available or it takes too long. So, please, that should be some of the things that you're looking at.

Managed care is neither as good nor as bad as

the total picture you've heard. And I invite you to spend three hours with me on the telephone as I call the HMO and it says, "First of all, if this is a medical emergency, call 911." Then you spend your time going through this system. You may or may not get an authorization. It is denied many times. Many times it's given, but then it's not paid. We give emergency care without prior authorization because that's the Hippocratic oath and that is humanitarian. We then ask and try to get the retro authorization. It's not forthcoming. We've never gotten retroactive authorization for emergency care. It's no longer an emergency. So, therefore, it's not given. So the cost containment is a big issue.

My husband is neither for nor against managed care because he's lost a good portion of his private practice to managed care. We're trying to join as many plans as we can. They're closed. Many of them are closed. We have joined many of them.

We give a great deal of care for people who have been our patients since 1972, who belong either to Kaiser or to a plan that we're not part of it. Doesn't mean my husband denies care. But this is in the cost factor that the HMO presents to you about how it's more reasonable to give managed care. We still give the care. We still have the patient-physician relationship.

So those are a few of the issues. I again invite you to spend three hours with me, listen to these phone calls, listen to the patients' problems. They don't

know where to turn. So they turn to me. My husband is frustrated. They turn to me, and I get on the phone wherever I can, and I address groups like this as often as I can because I commend the group.

And I thank you for the opportunity to talk.

DR. ENTHOVEN: Thank you very much.

Ralph Reece, followed by Kim Vuong, followed by Cy Cy Lambert and Paul Kriegel, then Tracy Lovelace.

MR. REECE: I'm Ralph Reece. I'm with the California Health Protection Fund. And between the rat and the company that he keeps, you know, I'd like to offer the task force an immediate statement regarding their position on being representative of the government of ours. The task force has therefore not even warned the governor that immediately we are addressing some immediate emergencies. We would like to bust that bubble, you know, the bubble that we've been running around with, calling managed care.

Managed care has taken advantage of a principle that started out in HMO's that was simply monitoring a physician practice. And that's what HMO's were doing as a major complement to their service. They managed what physicians were doing that was unconstitutional. Okay. But the concept of what we are is that we are talking about constitutional care versus health care treatment by the state of California providers, whichever level of provisions you want to choose.

Our immediate problem that we enter into is that we are not getting constitutional care. Constitutional care, which would provide for all those things that you're hearing people talk about today that would have instantly been considered and regarded and, if there had been a problem in the banking industry, such as, you know, abuses, they would call the police department. And they would say, "We have a potential abuser," or something or another. You know, falsifying, doing whatever they do. And they go pick them up or send out a detective, and he watched that problem.

Here we have no monitoring and no management. Here we have abusive that go without regarded positions of a government, a quote, unquote, state government, with the responsibility of a contract that says they will guard abuses.

So what they did was shift abuses down to the monitoring agencies or agencies that they assumed that the contract -- it didn't happen. Having the cat watch the mice is just not going to work.

The absolute bottom line for you is to make a decision today to resume the responsibility of actual service delivery that is monitored on all levels. It doesn't matter whether it's private, Medi-Cal, direct, Medi-Cal card stuff or, if it is otherwise under HMO's or managed care. Managed care has not proven itself anywhere.

These agents that have been individually

careful and doing well individually have never encountered some of the communities people who can be very difficult to work with. So I'm simply saying to you we can simply go back to the bottom line. Bottom line is that we need to police it at the state level, the contract. The contract here requires that, when you have a sanctioned organization that's undersanctioned, that they should not be provided continual contracts. After 12 months of failure, that contract should have been pulled by the state. It does still exists. You know what I'm talking about, which agency I'm talking about. You know exactly what is happening with the rest of staffing all around this state that are working for managed care. They know they're frightened to ever come here to a meeting to tell you the extreme disasters in managed care.

The doctors are frightened. They're subject to be at any time disconnected from service. This is invasion. So they can't tell you. We're here because we're not afraid of you nor the government. We're wanting you to warn the government. You're the first opportunity the government is going to have to get to visit us before we visit him.

So our suggestion to you is to go to the governor and say, "These people are not going to stay state commanded, discounted, quote, unquote, health care. Unconstitutional type. That kind that says, "We're just cutting the budget because we want to save money, and we're having a grand time." And "Oh, by the way, did it

hurt anyone? Oh, send the task force out and find out. Does this hurt? You guys tell us. Did we hurt anybody when we cut the budget?"

Ladies and gentlemen, they not only hurt the community. They've hurt it because they refuse to monitor what those cuts did and what it transpired from the state agency -- the state agency said, "We'll close our eyes if the governor does." It's your turn. Go back to the governor and say "No good." They watching. They're watching us. They're looking, and we're all looking. We're all looking. You see, we caught you, got you, got the governor. It's your turn.

DR. ENTHOVEN: Thank you very much, Mr. Reece.

MR. REECE: Thank you.

DR. ENTHOVEN: Kim Vuong. Cy Cy Lambert, Paul Kriegel.

MS. LAMBERT: This is Kim Vuong.

DR. ENTHOVEN: Welcome to our task force, Kim.

MS. VUONG: She said I'm her interpreter.

Kim says my name is Kim Vuong, and I have cerebral palsy, which causes me to have speech and motor skill related disabilities. I know that I am young, and some may feel I don't know any better, but I do. I have been living independently on my own for the last three years.

When I signed up with one of your managed

care programs, I was under the impression that it would give me the option to choose my doctors who would take better care of me. I've been on the Medi-Cal HMO program for three and a half years, and it doesn't work very well. Let me give you some of examples of my experiences with my HMO.

Last year I had a back injury. And my HMO provider did not provide the necessary medical treatment needed to keep me functioning. I had stayed out of school for one semester because my back was in extreme pain. To this day I still have pain in my back.

Another example that I can give was an accident a couple weeks ago. I was in Catalina Island with a friend and her family. My friend and I wanted to locate a bell that rang every hour on the island. A long story ending up short, we ended up falling 16 feet down a cliff. The emergency rescue team took us to the hospital. The doctor did ask if my neck or back or any part of me was hurt. I told him that my hand was hurting. But I didn't realize that my neck and back were affected. And I was experiencing dizzy spells for up to four weeks later.

After I went home from Catalina, I was very sick, and I went to see another doctor on the HMO provider plan. He recommended me to see my regular doctor, but he was not available for another couple weeks. The doctor told me that I was fine and I didn't -- and he did not do a full checkup. I requested for an MRI. I requested for X rays. But the doctor told me "No. You don't need one.

You're fine."

When I asked him "Why am I dizzy all the time?" he told me that I'm fine. "Go home and aspirins for the pain." I was not fine. I was still dizzy and could not do anything for myself. I was so sick that I could just sleep and sleep and sleep.

My number one suggestion is to mandate all managed care providers to allow second opinions as well as precautionary exams on all accidents. Remove the 15-day maximum therapy limit for back and injuries and other injuries which may require longer term care. Mandate funding for -- care so that persons like myself can live an independent, yet functional, life while avoiding institutionalization. With much concern Kim Vuong.

DR. ENTHOVEN: Thank you very much.

Next, Cy Cy Lambert.

MS. LAMBERT: I'm Cy Cy Lambert.

DR. ENTHOVEN: All right.

MS. LAMBERT: First of all, thank you very much for having your patience and time to come out and to go through all of California and get the information that you've been doing to do the job that's really heavy. A lot of work. I'm a mother of a spinal cord injured individual that occurred -- or what we call acquired disability seven years ago. But he doesn't fit under the developmentally disabled division because he was not brain-injured.

So it set me on a challenging journey as I

started to try to find and locate where I could get help through my managed care providers to assist me in assisting my son regain excellence.

Seven years ago I pioneered and journeyed with a lot of fear. And in the process of doing it, I started a foundation to assist other families. We're all volunteers. Nobody gets paid. And we're the missing link between the HMO's and all the different managed providers that isn't being taken care of that they're unable to handle. We work with spinal cord injured individuals that have been institutionalized into convalescent homes without the care.

Just yesterday I was with a 16 year old who was sent out of the hospital within a 60-day period because of the fact that time limit had ended. There's so much to share, and I don't have the words to share much more. Except that I have written up some information here.

We've given you some documented material, and I hope that you'll be able to look through it. We've also given some solutions as to what we have already been doing, volunteering me in trying to help individuals to continue on in a productive life.

You heard Maxine Stewart. She not only has a productive life. She also works with us now as a have volunteer, training caregivers, HMO providers, as to how to care for paralyzed individuals. And we're not paid for it. She's not paid for it. We do it because we know

there's a need out there, just like you guys know there's a need out there. That's why you're here. God bless you and good luck.

DR. ENTHOVEN: Thank you very much.

Paul Kriegel. Not here.

Tracy Loveless. You're in the cleanup hitter role.

MR. LOVELACE: I'm Tracy Loveless. I'm a pharmacist, a pharmacy owner, and a Medi-Cal provider.

I'm sure you're aware of the L.A. County plan that is to be implemented soon. This is the greatest changeover of a population of people into a different health care plan in this country's history. And there needs to be guidelines for the HMO's that will be taking care of these patients.

Currently the HMO's pretty much do what they want. There's very little regulation for the HMO's. When it comes to patients in the Medi-Cal population, you have a great population of poor people, people with reading disabilities, people with perhaps poor reasoning skills, and at this point they are being directed to choose a particular HMO, not being given the proper information or having the tools to make such a choice.

The patients are more or less at the mercy of the HMO's. The HMO's primarily are for profit, which means profit comes before patient care. In a population of people that are not properly informed, perhaps poorly educated, language barriers, this is a very critical

problem.

A group of us pharmacists in L.A. County have been told over the last two to three or four years that the state has chosen to go this route due to an emergency situation. To this date, no one has been told what the emergency was. But this is the route the state wants to take.

We have been told by Department of Health Services that the change to managed care was to improve accessibility and quality of care. That's almost an oxymoron to allow the managed care and HMO's to do this. Cost was not a factor.

The same Medi-Cal dollars used in fee for service would be used in managed care services. So cost was not a factor. They're not trying to save costs. This is what we're told.

We don't believe it. Currently in L.A. County, where this is to take place, there are 1,200 pharmacies, including chains, independent pharmacies like my own. We're currently contracted with Medi-Cal. By leaving it to the HMO's, they would direct 100 percent of the prescription business to approximately 200 pharmacies, which would be chain pharmacies. They don't provide the same scope of care that independents provide. They don't provide the same services necessarily.

We have personnel in our pharmacies that speak different languages. We provide services such as delivery. We counsel patients. We provide many more

services than the chains. However, leaving it to the HMO's and managed care plans, we would be easily removed. We are being forced to deal with this issue. It's an impossible situation for us to deal with.

The pharmacies that are being allowed contracts to provide prescriptions to these HMO patients are being offered contracts at reimbursement rates that are below cost for the pharmacy.

We're being forced to work within an HMO setting, without having the benefits of HMO purchasing power. We are not given special contracts with the manufacturers of medications such as the HMO's to purchase medications at percentages much less than what independents are able to purchase at. They're 50, 60 percent cheaper. Yet we are being reimbursed on similar or same levels as the HMO's that are purchasing medicines at sometimes pennies on the dollar. This is strictly a for-profit angle that HMO's have.

We're being unfairly discriminated against, and I don't mean racially. I mean independent pharmacy owners and the chain pharmacies. We're being driven out of business. Patients we've been caring for for years when the pharmacy is 15 years old, and we're being forced out. The HMO's need regulations.

We believe in the patient Bill of Rights and -- that has been passed through the legislation and the assembly and the state and the government has decided to veto. We encourage that you encourage the governor to

sign these measures to protect the rights of the patient that will be placed in HMO's at some point in time, the greatest move in this country's history. And there's very little information being passed on to the public.

I don't see why the state cannot have a public hearing televised. There's a state channel. Comes on every morning at 9:00 A.M. I don't understand why it's not televised. I don't understand why it's not on the news. A multibillion dollar event is going to occur when this changeover is finally allowed.

So far, HICFA has prevented it from going live in the last several months. It's now been put off until October and, I believe, January for Foundation Health. This is an extremely urgent matter, and I believe it requires all your attention to look at the list and give some guidance and some regulations to govern the HMO's.

Thank you.

DR. ENTHOVEN: Thank you.

The Managed Health Care Task Force meeting is adjourned.

(Whereupon the meeting adjourned at 7:00 P.M.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF LOS ANGELES)

I, Corinne L. Horne, Certified Shorthand Reporter in and for the State of California, do hereby certify:

That the foregoing 302 pages were taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision; that this transcript contains a full, true, and correct report of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED this _____ day of _____, 1997.

_____
CORINNE L. HORNE, CSR 8712